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ABSTRACT

Serving as a vehicle for raising the profile of and thereby gaining recognition for the important research and development work being conducted in Canada in support of children and families, the "Research Connections Canada" series compiles research and/or development papers as well as background papers, analytical literature reviews, and essays. This issue of the series focuses on quality in child care, and on training for family child care. The papers are as follows: (1) "Quality Child Care and Partnerships with Parents" (Marilynn Kuhn), on building and maintaining collaborative relationships with families; (2) "Regulations as a Strategy for Promoting Quality in Child Care Settings" (Gillian Doherty), exploring desirable levels of regulation and the extent to which current Canadian child care regulations support and encourage quality; (3) "Literature Review of Training and Family Day Care" (David Boisvert), identifying what the Canadian, British and American literatures reveal about the need for, implementation of, and design of family child care training programs; and (4) "Ontario Home Child Care: Providers' Reports of Training and Educational Experiences" (Irene Kyle), summarizing home child care providers' comments about their interest in and experience with taking part in a variety of formal and informal training and educational opportunities. All of the papers contain references. (HTH)

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Research Connections

CANADA

Supporting Children and Families

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Research Connections Canada is a bilingual publication series published by the Canadian Child Care Federation and funded by Child Care Visions, Human Resources Development Canada. The series is an anthology of current Canadian early childhood research and development papers.

This professional publication serves as a vehicle for raising the profile of and thereby gaining recognition for the important research and development work which is being conducted currently in Canada, including that being done under Child Care Visions, Human Resources Development Canada.

Research Connections Canada includes research and/or development papers as well as background papers, analytical literature reviews and essays. This publication *series is of particular interest to training programs (at both college and university levels), academics, researchers, policy makers and licensing and regulatory agencies.*

Research Connections Canada is guided by an editorial committee. However, the papers represent the opinions of the authors and should not be considered as reflecting the opinions of the Editorial Committee, the publisher or the funder. Papers are presented essentially as submitted by the authors; there is no substantive edit or fact-checking. There is currently no peer-review process.

One copy of each issue of the series is distributed free of charge to an identified distribution network including: libraries in colleges and universities that offer training in early childhood care and education; government child care departments; national organizations in the health and social services sector; and provincial/territorial organizations with a focus on early childhood.

Table of Contents

Quality Child Care and Partnerships with Parents 5
by Marilynn Kuhn
Changing Ideas 6
Catalysts for Change 9
Partnerships – Challenges 11
Partnerships—Goals and Benefits 17
Building Partnerships 21
Conclusions 28
Acknowledgements 30
Endnotes 31
References 34
Further Reading 36

Regulations as a Strategy for Promoting Quality in Child Care Settings 37
by Gillian Doherty
Introduction 37
Limitations of regulations as a mechanism for quality assurance 38
Desirable regulatory levels 40
Extent to which Canadian regulations support quality 41
Conclusions 47
Endnotes 48
References 49
Appendix A - Key informants 51
Appendix B - Overview of centre child care requirements by jurisdiction, 1998 52
Appendix C - Overview of family child care requirements by jurisdiction, 1998 58

Literature Review of Training and Family Day Care 63
by David Boisvert
Training and the Quality of Child Care 64
Training and the Professionalization of Caregiving 67
Measuring the Quality of Family Day Care 68
Evaluations of the Quality of Family Day Care 70
Design and Delivery Issues 72
Conclusions 75
Endnotes 77
References 78

TABLE OF CONTENTS

Ontario Home Child Care: Provider's Reports of Training and Educational Experiences 81
by Irene Kyle
Research Stance 81
Methodology 81
Findings 89
Implications for Developing Education and Training Programs 107
Endnotes 108
References 109
Bibliography 109

Quality Child Care and Partnerships with Parents

by Marilynn Kuhn

Marilynn Kuhn, M.H.A., is a private consultant with a background in adult education and health promotion. She has managed a wide range of research, writing and resource development projects, many in collaboration with organizations promoting healthy child development.

Abstract

How do early childhood practitioners and families build and maintain collaborative relationships? Kuhn provides discussion on partnerships between practitioners and families drawn from selected literature and key informant interviews in an attempt to answer this question.

Changing environments (e.g. demographics, social/legal framework) have necessitated centres and care changing from approaches that focus solely on the child as a client to that of "family-centred" care. This shift implies a change in values, belief and attitudes on behalf of practitioners. These "partnerships" between practitioners and families appear to be the way of the future, and various methods to build partnerships, empower parents and achieve the goals of families are outlined.

Overview

No one has a greater stake in the quality of child care than parents...[1]

[C]ollaborative relations with parents and work within a family context do not come about naturally or easily.[2]

This paper contributes to an ongoing dialogue on quality child care by exploring what has been discovered about building and maintaining collaborative relationships between early childhood practitioners[3] and families.[4] Even though there is a long history of parental involvement in child care, research on parent–practitioner relationships is limited and the voices of parents are seldom heard in discussions of quality. Increasingly, however, experiences from other countries and cultures, as well as within North America, are revealing

the importance of involving multiple stakeholders, especially parents, as partners in defining and realizing quality care and education for young children.

This paper draws on selected literature and several key informant interviews to discuss partnerships between child care practitioners and families in terms of:

- changing ideas,
- challenges and rewards, and
- strategies for building stronger partnerships.

Changing Ideas

Early childhood practitioners welcome families' participation in their children's education and care in many different ways. Families volunteer to help with activities. They serve on boards. They participate in events. However, ideas that have traditionally shaped the nature of this "involvement" have been changing. Galinsky and Weissbourd[5] described the shift as a move from a "focus on the child as the client" to that of the "parent–child relationship." Larner[6] envisioned the early childhood field moving "beyond its traditional boundaries, to create new services for families and new partnerships with parents." Powell[7] discussed a "more inclusive...approach," which he described as programs that "work with children and parents within their family contexts." These approaches are described in contrast to traditional expert-driven models of service or views of early childhood programs as compensatory for family deficits.[8]

A number of conceptual, legal and demographic changes over the past 30 years have converged to challenge traditional perspectives related to working with parents. These trends include:

- an increased emphasis on "rights," including parental rights;[9]
- thinking that goes beyond parental education to ideas of parental empowerment;[10]
- increased recognition and acceptance of a diversity of family structures, values and cultural traditions in response to the increasing diversity of the North American population;[11]
- an evolving ecological understanding of children and families that acknowledges the interrelationships of experiences at home, at work and in the community; [12] and
- a move to a more preventive, holistic approach to human services, including the recognition of social support as a preventive strategy;[13]

Increased numbers of family resource and support programs have been one response to this changing environment. Their guiding principles have been summarized as:

- partnership: a relationship of equality and respect between the program and family;
- empowerment: a view of participants as a vital resource to the program and to each other;
- cultural competence: programs grounded in the community they serve and culturally and socially relevant to the families;

- services to build parenting strength: information and skill building for parents integrated into every program; and
- voluntarism: all programs voluntary, and "seeking support and information viewed as a sign of family strength, rather than deficits and problems."[14]

The child care sector has also been influenced by these trends as seen in the following statements of the Canadian Child Care Federation on occupational standards for relationships with families. They state that practitioners should:

- establish and maintain an open, cooperative partnership with each child's family that supports the family in meeting their responsibilities for the child; and
- strengthen the adults in the family in their roles as parents, nurturers and providers and empower them to act on their own behalf.[15]

Partnerships with families is a central theme in many recent early childhood publications, such as:

- *Partnerships in Family Support: Family Centred Practice* (the Partnerships Project) is a training manual for an inservice program designed specifically to assist early childhood practitioners. It addresses the following changes in philosophy and practice:[16]
  - from a single subject (child) to a system (family) approach;
  - from a primary focus on professional expertise to a partnership model that recognizes the expertise of both professionals and families; and
  - from focusing on deficits to building on strengths of child and family.

  Other shifts highlighted in the Partnerships Project include:
  - responsiveness to family needs rather than system effectiveness;
  - a holistic rather than a discipline-specific approach; and
  - an inclusive environment and right to participation rather than segregation and special services.
- *Survive and Thrive!* outlines the experience of several rural Ontario communities in their move from traditional practices to "community-driven" services. Their program is based on:[17]
  - a commitment to understanding community needs;
  - participation of families in decision making, program design and working for change;
  - partnership with local organizations and institutions in achieving shared goals;
  - community consultations soliciting the input of parents and other partners in solving problems; and
  - flexibility in continually reshaping programs and services to be responsive.
- *Partnerships: Families and Communities in Canadian Early Childhood Education*[18] is a resource "for faculty, students, and teachers in early childhood environments to encourage

the development of positive and respectful relationships with all types of families." It is also intended to help early childhood programs "adapt and respond to the needs of families as opposed to requiring that families adapt and respond to the programs."[19]

The concept of partnership, although not explicitly defined, consistently includes:

- a respectful, collaborative relationship between families and practitioners,
- shared responsibility for decision making;
- recognition that each participant brings valued resources; and
- active contributions by all parties to achieving their shared goals.

Powell[20] described partnerships as "collaborative, co-equal relationships." Chud and Fahlman[21] highlighted the need for a commitment to and genuine respect for families and children by practitioners.

The concept of "family-centred" care is closely associated with that of practitioner-family partnerships. A "child-centred" approach often expects families to adapt and respond to services for children. A "family-centred" approach tries to adapt and respond to the needs of the family.[22] Children's development is supported, not only by providing quality programs for the child, but also by supporting families in ways that empower them to support their children.[23]

The road from parental involvement and positive, respectful relationships between families and early childhood practitioners to partnerships based on a family-centred approach has many steps along the way. Some aspects of this approach, such as making parents feel welcome and ensuring that they feel free to ask questions and participate, are already integral to best practices. Others, such as non-judgmental dialogue and openness to change in response to parents' input, require a major shift in perspective for many practitioners. They are not simply an add-on to current practice, but a rethinking of basic assumptions about working with children and families.

No data are available on what proportion of child care centres and family child care homes try to practise a family-centred approach. There are certainly some, including those interviewed for this paper.[24] Each of the key informants strongly supported this approach, and saw their own efforts to be "family-centred" as a work in progress—an ongoing journey built on experience and continuous learning.

Although there is a considerable body of theoretical literature highlighting the importance of partnerships with families in early childhood care and education, little research evaluates this approach. The following discussion draws from many areas of research to summarize current discussions related to this issue.

Catalysts for Change

The current shift in thinking and practice related to working with families has been driven by a number of factors affecting all those who are involved in the provision of human services. This section briefly examines several of these factors and their implications for early childhood practitioners.

Demographic Changes

Profound demographic and social changes of the past 30 years have had an impact on early childhood programs. These include increasing racial and ethnic diversity, increased participation in the labour force by women with young children, more poor children, and increasing numbers of children living in "non-traditional" family structures.

Changes in Canadian immigration patterns have led to greater diversity of race and culture in child care settings, particularly in larger cities. Between 1991 and 1996, more than a million immigrants came to Canada.[25] Compared to three decades ago when immigrants were largely from the United States, Britain and western European countries, in the past decade, the majority have come from Asia and the Middle East. This means that most immigrants are now members of visible minority groups.[26]

An increase in women's labour force participation has meant more children requiring child care. Between 1975 and 1997, the percentage of all mothers with the youngest child under 3 years participating in the labour force increased from 31.2% to 64.1%. For all mothers with the youngest child between 3 and 5 years of age, the increase was from 40.0% to 68.8% during the same period.[27]

Many families require two incomes to avoid poverty. In 1991, the incidence of poverty in families with at least one child under age 12 decreased from 92.9% for families with no earners, to 29.7% for families with one earner, to 6.2% for families with two earners.[28] Analysis based on the National Child Care Study demonstrated that, in 1988, 12.6% (278,000) of two-parent families with children under age 13 had family incomes below Statistics Canada's 1987 low-income cut-offs. If both parents had not been working, the number of two-parent families with incomes below the poverty line would have been 550,000, that is, almost double.[29]

The number of lone-parent families also increased by 60% from 1981 to 1995.[30] Living in a lone-parent family means children are much more likely to be poor. In 1991, a Statistics Canada survey reported that 12.4% of families whose youngest child was under 7 were living below the low income cut-off. For lone-parent families, the corresponding percentage was 69.2%.[31]

Increasingly, children are living in non-traditional families. "About one in six Canadian children experience the separation or divorce of their parents—a proportion that has tripled in the last 20 years."[32]

These factors have led to a more diverse population of children needing early childhood services. Greater diversity has meant that child care practitioners are more frequently caring for children whose race, culture, socio-economic circumstances or family composition is significantly different from their own experience.

New Research

Several streams of thought and research in the past two decades have contributed to shifting paradigms related to support for families. Bronfenbrenner's ecological model of human development[33] and research into the critical aspects of brain development in the early years[34] have focused attention on the significance of early childhood environments and experiences. A shift in thinking about helping behaviours has focused attention on working with people's strengths rather than their deficits.[35] This shift has reframed the helper's role from one of providing answers to solve people's problems, to one of working with individuals and groups to support them as they define and pursue their own goals and solutions. This approach has challenged traditional expert-centred models of help.[36] It has also been accompanied by a growing self-help movement. Finally, research into cross-cultural relations and child development has led to questions about applying norms based on North American theories of child development to children of different cultures.[37]

The influence of immediate and more distal environments on child development is central to Bronfenbrenner's ecological model.[38] In this model, children are understood in the context of their families. Families are influenced by the communities in which they live and both children and families are influenced by the larger society of which they are a part. Bronfenbrenners's theories have influenced thinking in many areas related to child care and early child development.

Ecological approaches are complemented by family systems research. This research recognizes the family as an interdependent unit within which changes with one element have an impact on the others.[39] For example, a mother's decision to return to full-time employment not only affects her, but relationships among everyone else in the household.

Research into critical periods of brain development has also focused attention on the role of families and other care providers in the early years.[40] This research has highlighted the profound influence of the daily interaction of families with their young child on the physical development of the child's brain, and the importance of early brain development as a foundation for future social, cognitive and emotional development. It has reinforced the importance of supporting families as nurturers and teachers of children in the early years.

Social and Legal Framework

Consumer and human rights movements in the past three decades have had an impact on both public consciousness and legislation. Together with other professionals in human services, early childhood practitioners have become more aware of issues of bias and inclusion. Parents, too, have become more conscious of their rights and more demanding of appropriate services for their children, particularly children with special needs. Challenges to the status quo by consumer and human rights advocates have helped fuel disillusionment with professional or expert approaches to many problems and encouraged the formation of self-help groups.

The concept of empowerment has emerged in this context. Powell[41] described empowering relationships as those in which staff "serve as facilitators of goals and activities which are determined jointly by parents and staff. Notions of empowerment pose a direct challenge to expert-client models of relationships.

Awareness of Other Experience

International comparisons of policies and practices related to families and young children have revealed successful alternatives to the North American approach to child care.[42] Some of these are based on collaboration with parents and other community members. While these alternatives emerge from a different context, they have broadened the lens through which early childhood education and care has been viewed. The experience of intense involvement of parents and other community members in planning and implementing child care in the district of Reggio Emilia in Italy is one example of how early childhood practitioners work successfully with parents and with a broad range of community resources to plan and deliver early childhood care and education.[43]

Impact of These Trends on the Child Care Sector

Together, these trends have had a major influence on both the theory and practice of human service professionals, including those in the child care sector. They have focused attention on the importance of parents as primary caregivers, and hence the importance of partnering with parents to promote healthy child development. They point to parents as necessary partners with child care practitioners as they respond to cultural diversity, integrate children with varying abilities into programs, and generally attempt to make programs more responsive to and inclusive of families.

Partnerships – Challenges

Research and theoretical literature reflects a broad consensus about the importance of family-practitioner partnerships. However, there is limited clarity about the meaning and nature of parental involvement and little empirical research evaluating either how the relationship evolves or its impact.[44] On the other hand, there is considerable evidence pointing out the challenge of building effective partnerships.

The following sections discuss some of the challenges to providing family-centred child care. Although "partnership" implies a two-way relationship, the discussion focuses primarily on the challenges as experienced by early childhood practitioners, since they are the ones seen to have the primary responsibility for creating the conditions in which a positive relationship can develop.[45]

Values, Beliefs and Attitudes

The values, beliefs and attitudes of early childhood practitioners strongly influence how they structure children's learning environments, mediate children's experiences, and work with families.[46] In their study of multicultural child care in Alberta, LaGrange, Clark and Munroe noted that these practices are based on "deeply held beliefs about what is best for children."[47]

Wilson cited the following core beliefs as central to programs committed to family-centred, culturally sensitive child care:[48]

- the family is central to a child's life;
- each family has its own strengths, competencies, resources and ways of coping;
- each family must be accepted and respected on its own terms, without judgments or preconceptions;
- the racial, ethnic, religious and socio-economic diversity of families must be honoured; and
- services and programs are effective only insofar as they support a family in meeting its own identified needs and concerns regarding child care.

These beliefs may or may not be congruent with those of individual practitioners.

Several authors[49] noted the importance of a practitioner's self-awareness as a starting point for building positive relationships with families, particularly those whose values and beliefs may differ. In her study of cross-cultural competence, Lynch concluded: "It is not possible to be truly sensitive to someone else's culture until one is sensitive to one's own culture and the impact that cultural customs, values, beliefs, and behaviors have on practice."[50]

In other words, appreciation of how you have reached your own values and beliefs is the basis for appreciating other values and beliefs based on different experience.

Much research to date, exploring practitioners' attitudes toward parents, has concluded that many practitioners "harbor negative feelings about parents."[51]

What Prentice and Ferguson[52] referred to as the "motherhood mandate" is one factor that can influence attitudes of caregivers and parents. A study by Galinsky, Shinn, Phillips, Howes and Whitebook found 24% of early childhood staff were "staunchly against mothers working."[53]

A significant proportion (25%) of mothers also felt they should be home with their children, and 68% felt they should work less. Staffs' disapproval and mother's guilt may feed into one another, leading to poorer parent–practitioner relationships.

The Galinsky et al. study found that practitioners tended to be less judgmental if they approved of maternal employment, were more committed to their jobs, and believed in the importance of working with parents.[54] Kontos, Raikes and Woods[55] observed that older, more educated staff tended to be more positive and that attitudes generally became more positive when dealing with older, wealthier, more educated mothers.

Leavitt's study[56] of a small number of family child care providers also found them to be judgmental about parental competence. Although the study was too small to be generalized, it is worth noting because it combined interviews both with parents and practitioners and on-site observation over a period of 18 months. It was only after spending time with care providers in observational periods that their negative feelings about parents and their child-rearing practices were expressed to researchers.

The challenges of bridging different beliefs and attitudes is magnified when families and practitioners come from different cultural backgrounds. Child development, as taught in most training programs, is based on the norms of white, middle-class North American culture.[57] The research of Bernhard, Lefebvre, Kilbride, Chud and Lange into parent–teacher interactions in ethnoculturally diverse child care settings found that practitioners and "minority parents appeared to have substantial differences over what constitutes proper child-rearing methods in the home."[58] Practitioners, although they—particularly more recent graduates—had received some training, did not feel adequately prepared.[59]

A study by Elicker, Noppe, Noppe and Fortner-Wood[60] suggested that the judgment teachers make of parental competence may, in turn, affect their interaction with parents. Another study found that practitioners had less daily communication with mothers who were perceived to be less competent.[61]

Partnerships require agreement by both parties to collaborate. Parental beliefs and attitudes, no less than those of practitioners, affect their decisions to become involved with their child's early education and care. In a review of research literature on parents' involvement in their child's formal education, Hoover-Dempsey and Sandler[62] identified three factors that influenced parents: their understanding of their role in relation to their child's education; their sense of being able to help their child succeed; and the opportunities they were offered for involvement. This research suggested that simply providing opportunities for involvement may be necessary but insufficient if parents' attitudes and beliefs related to the first two factors are negative.

Risks/Fears

While parental involvement has a long history, concepts of family-centred practice and partnership relationships with parents are relatively recent. For most practitioners, implementing these ideas involves a significant change in practice. Change is not easy. Three of the four key informants spoke of the challenges involved for staff in the transition to a family-centred, partnership model for working with parents. In one centre, staff demonstrated a strong resistence.[63] In another, minor gains made during a pilot project were difficult to sustain.[64] A third noted, based on her experience training staff to make this transition, that practitioners find the change very uncomfortable and require both psychological and emotional preparation. They need to deal, at many levels, with the implications of reframing their traditional expert role, to one of facilitator and co-learners and co-teachers with parents.[65]

It is normal for change to be perceived as risky and to generate some level of anxiety or even fear. This fear of change can be heightened when few models exist, training is not available and new ways of working are not well understood. Concern and frustration also increases when practitioners feel their previous efforts to involve parents have not been successful and their work has not been appreciated.[66] Fear of a loss of power and control in shifting from an "expert" role to one of sharing ideas and decision-making power with families can be another concern.[67] In opening their work to greater parental involvement, practitioners may also feel more vulnerable to criticism and unreasonable demands. Or, given their judgments of parents' competence, they may have concerns about how parents, once involved, will deal with young children.[68]

Experience of trainers at the Abilities Centre in British Columbia, who work with child care staff to develop family-centred practice, has been that, in most cases, these fears are not founded. In almost all situations, families are not unreasonable: they appreciate staff efforts to be responsive to their needs and they make suggestions for dealing with issues that would have been impossible for staff alone.[69] This experience is confirmed in the research of Prentice and Ferguson on mothers' involvement in child care delivery. Mothers' primary interest in involvement was not related to a desire for "control" but to their wish to contribute to making their centre a "caring" place.[70] Research by Endsley, Minish and Zhou[71] also suggested that caring and positive relationships rather than program management are the primary reason for parental involvement.

Parents, as well as staff, may perceive some risks in developing partnerships. Their reluctance may be associated with previous negative experiences with schools. They may feel vulnerable to criticism of their parenting skills by staff, or be concerned that their child is vulnerable if they make suggestions that could be perceived as criticisms.[72] These concerns could be even greater for immigrant parents and parents from minority cultures. If they are

not fluent in the language spoken at the centre or in the family child care home, they may not be confident that they will be understood. They may sense a lack of respect and understanding of their culture and choose to remain silent rather than be defensive or misunderstood. Or, it may be unacceptable within their culture to question people who are in an "expert" role.

Differing Perceptions and Priorities

A strength of parent–practitioner partnerships is that each party brings different resources and ideas which, theoretically, increase quality care. A challenge, however, is that each party sees quality through a somewhat different lens. Families view issues in terms of their own child and family. Practitioners, on the other hand, bring the perspectives of their training in early childhood development and of managing complex daily routines with groups of unrelated children. Both have multiple, sometimes conflicting, roles and priorities. Without a foundation of respect and good communication, these diverse points of view become sources of stress rather than strength.

Seeing stereotypes rather than individuals can colour the perceptions of both practitioners and parents. Practitioners may make assumptions about parents from different cultural or socio-economic backgrounds. Parents may make assumptions about caregivers based on brief encounters and limited knowledge of what goes on all day.

Different experiences of the child can be a source of tension. Practitioners see a child in the child care setting and have opportunities to observe the child interacting with other children. They see the child with his or her parents primarily at transition times in the morning and afternoon, a time when parents are often rushed and stressed. Parents often have limited opportunity to see their child interact with other children. They do, however, see the child interacting at home, with extended family and with neighbours and friends.

Practitioners and parents may also have different interpretations of parental involvement or lack thereof. Staff may attribute parents' lack of involvement to lack of interest in their child's experiences in the family child care home or centre, or a lack of respect and support for their work. However, parents are not a homogeneous group. There are many possible impediments to their participation. Not all parents have the same degree of openness, interest or ability to be involved. As one key informant stated, practitioners have two major tasks in terms of engaging parents: to make as many opportunities as possible for involvement and to deal with the fact that some parents do not want to be involved.[73]

It may be difficult to know which factors influence parents' willingness to be involved. Parental participation in information-sharing events increased at one centre when the planning was done by a parents' group, even though many of the topics and speakers were no different than those previously arranged by staff.[74]

The daily communication—often limited to brief discussions at transition times—that filters the perceptions of practitioners and parents also presents challenges. Parents generally are more satisfied than practitioners with the level of communication.[75] One study suggested that practitioners have higher expectations that parents will provide them with important information, while parents were more interested in "friendly communication."[76]

Infrastructure

Just as quality care is linked to supportive environments,[77] the capacity of individual practitioners to build collaborative partnerships with families is linked to the support they receive. This includes preservice training, professional development opportunities, leadership, appropriate policies and access to resources. Some indicators suggest such support is increasing, but far from universal.

Bernhard, Lefebvre, Chud and Lange[78] reviewed current early childhood education curricula to assess efforts to incorporate training for working effectively with culturally and ethnically diverse families. They noted that recent graduates (post 1988) felt more prepared to work with diverse populations, but also concluded that much more needs to be done. They suggested that skills and theory related to a collaborative approach and to working with families from diverse backgrounds need to be addressed in both theory and practice throughout the curriculum.

Key informants stressed the importance of continuing education in supporting practitioners' attempts to implement family-centred practice. They felt that most students require experience in the field before they are prepared for meaningful learning related to the complexities of working with families. Accessing resources for continuing education is a challenge to pursuing this. For many of the participants in the Partnership Project in British Columbia, particularly family child care practitioners, this workshop was their first opportunity for continuing education. Fees are often prohibitive and, for family child care practitioners, loss of salary acts as a further barrier.

Lack of resources is an issue generally for the child care sector. The kinds of changes proposed in the partnership model of working with families require opportunities for learning, for testing new behaviours and for reflection on experiences. Financial resources help to purchase training opportunities, facilitate networking, and reduce some of the pressures of day-to-day operations that ease the transition to new ways of working. The challenges of change in a situation with high demands and limited resources are evident in the evaluation of the Health and Diversity Project.[79]

Nevertheless, there are examples of care providers who are committed to a transition to a family-centred approach to care. Their experience is used to illustrate comments made in the section on building partnerships.

Partnerships — Goals and Benefits

Partnerships are built on shared goals. Early childhood practitioners and families share the goal of supporting the well-being of the children in their care. However, defining more precisely what this partnership means and developing strategies to achieve it is a significant challenge. In general, both the goals and the strategies for working with children and families have been defined largely by practitioners based on their knowledge of child development and assumptions about developmentally appropriate practice. As outlined in the previous section, opening these core activities to substantive input from families poses many challenges. The following section reviews what has been said in the literature about goals for family involvement and its benefits. The subsequent section takes a brief look at further goals, not addressed in the literature, that families might have for investing in this partnership.

Goals of Partnership in Research Literature

While theoretical support for parental involvement in child care is strong, empirical research on its benefits is scarce.[80]

Much of the research on the involvement of parents in child care comes from early intervention programs involving low-income families.[81] Additional insights into working in partnership with families have come from work with families that are in some way "different" (e.g. who come from a different culture or class, or whose children have differing abilities or exceptional learning or behavioural problems). It is assumed in the following discussion that all of these experiences working with families have relevant lessons for partnerships between practitioners and families in general. As suggested by key informants and others, each practitioner–family relationship is unique and needs to be examined individually.[82] Responding to various dimensions of diversity, in the end, means responding to the uniqueness of each family.

Shimoni[83] found that, although there is great diversity in definitions of "involvement," four broad program goals for working with parents appeared in the literature:

- providing parents with opportunities to enhance parenting skills, sometimes referred to as parental education;
- providing parents with opportunities to influence their children's program;
- enhancing the continuity of care between home and the child care setting; and
- empowering parents.

A theme underlying each of these goals has been "a desire to support parents in their child-rearing roles."[84] The following sections discuss these goals in terms of traditional approaches to child care, and their meaning in a partnership-based, family-centred approach to child care.

Parental Education

Parental education has probably been the goal most examined over the years by researchers in relationship to the involvement of parents. However, understandings of what it means and how to approach it have changed considerably over time, leaving even the term itself in question.

A review of evaluations of traditional parental education strategies by Shimoni found limited evidence of any related change in families. Programs that did show some success were intensive and extensive, and resourced at levels well beyond programs in child care centres.[85] It may be that these perceived weaknesses of traditional approaches are, by themselves, a force for change.

The following statement of changes in how "parental education" is understood comes from the literature and from key informants. The changes include shifts:

- from one-way communication from the "expert" to the parent, to a two-way dialogue for "sharing information" between partners, each of whom has expertise to offer.[86]
- from prescriptive answers to joint planning and problem solving related to the needs and goals of a particular child and family;[87]
- from professionally chosen topics to responding to parents' concerns and interests;[88]
- from a focus exclusively on the child to a focus on issues as they impact on the whole family;[89] and
- from an emphasis on teaching through lecture and discussion to one of learning through experience and reflection.[90]

As this shift takes place, parental education is no longer grounded only in a body of expert knowledge about child development, but in a process for sharing information and experiences and jointly building knowledge. This process is consistent with notions of partnership and is associated with the concept of empowerment.

No research was found that examined the effectiveness of this approach. However, key informants provided several examples of how collaboration with parents had led to mutual learning and creative solutions to problems that benefitted the family and the child.

Parental Influence and Control

Being genuinely open to parental influence is central to realizing parent–practitioner partnerships, but this can be a complex and sensitive issue for practitioners.

A common mechanism for parents to influence programs in non-profit centres is participation on a board of directors. There has been little research on the actual impact this mode of participation has on policies or programs. A small study involving 49 mothers in Winnipeg

concluded that they did not see participation on the board as a significant resource for input into their child's care.[91] Understanding why this was the case, for these mothers and possibly others, and, if there are conditions under which board participation can be meaningful, are questions for further research.

Parents can also influence programs informally through their participation and communication with practitioners. However, parents' effectiveness through informal participation depends on practitioners' sensitivity and good will. Existing research suggests that practitioners and parents do not always agree on what is good practice generally,[92] or on best practices for specific children.[93] Practitioners' ability to explore areas of disagreement in a non-defensive and non-judgmental way with parents is a measure of their skill and their commitment to a partnership approach.

Powell explored the tensions for practitioners that are inherent in having indicators of quality defined as developmentally appropriate practice (DAP) on the one hand, and being open to genuine collaboration with parents who may have some goals that are not compatible with these professionally determined standards on the other. His view of the DAP statement in 1994 was that it seemed to "reflect a profession in an understandable quandary about how to accommodate parents."[94] A revised statement of DAP in 1997 has gone some distance in attempting to deal with this "quandary." The introduction to the guidelines begins with the statement: "Developmentally appropriate practices derive from deep knowledge of individual children and the context within which they develop and learn."[95]

The statement acknowledges the "complexity of the partnership between teachers and parents,"[96] and provides the following statement as the initial guideline for practice: "Reciprocal relationships between teachers and families require mutual respect, cooperation, shared responsibility, and negotiation of conflicts toward achievement of shared goals."[97]

There is limited research which asks families how they would like to influence programs. Their perspectives on quality are known to vary with their child's age, being a member of a minority or immigrant group, and having a child with special needs.[98] In general, they are more favourable than practitioners toward activities that prepare young children for school.

Continuity of Care

Continuity of care is a third goal reflected in the literature on parental involvement in child care. It refers to the degree of consistency a child experiences (e.g. values, language and behaviours) moving between home and a child care setting. To the extent that home experiences are reflected by staff in the child care setting, the child experiences continuity or discontinuity. A high degree of continuity in a child's experience has generally been considered positive since it helps to reinforce the values and practices of the family and minimize distress of the child.[99] If there is significant discontinuity, it is expected that child

The following sections explore several areas of support important to realizing family–practitioner partnerships. Each section outlines a different thread related to developing and maintaining partnerships with families. Although they are described separately, in fact they work together and are mutually supportive.

The Foundation

As has been suggested, a shift in the relationship between practitioners and families from one of an expert service provider to a partnership model is difficult. It involves an openness to examining beliefs, values and attitudes, as well as behaviours. Essential qualities in making this transition are (summarized from Shimoni & Ferguson[114] and Chud[115]);

- an understanding of one's own values and attitudes;
- an openness to change;
- the flexibility to make changes;
- willingness to explore the unknown and make mistakes; and
- open, respectful, non-judgmental communication and attitudes.

While classroom learning can contribute to these qualities, they are nurtured through hands-on experience and opportunities to reflect on that experience in a supportive environment. They are acquired in a developmental process.

Partnerships are also developmental in nature, evolving over time as individuals build confidence and trust in one another.[116]

Effective communication, including cross-cultural communication, and a "commitment to the acceptance and appreciation of all forms of diversity"[117] are the foundations both for learning about partnerships and for building and maintaining them.

Training

Education and training are central to developing the skills, knowledge and attitudes needed for working as partners with families. Since family-centred practice has been closely associated with diversity training, the following comments are drawn largely from work in this area. However, as previously stated, the skills needed by practitioners to work with families that are most obviously "different" are assumed to be generally relevant to work with all families.

Sparks summarized three essential tasks for practitioners to "find out what [they] need to know to care sensitively for each child."[118] These tasks are to develop awareness of their own cultural beliefs and values about how children develop and the best ways to nurture and raise them; practise strategies for discovering other people's cultural assumptions; and learn and practise problem-solving strategies for negotiating and resolving conflicts.[119]

In a review of diversity and equity issues in childhood education programs, Bernhard et al. listed the following performance expectations from work being done in Ontario:

- recognizing and expressing the value of diversity and commonality;
- designing an inclusive curriculum and environment;
- implementing experiences for children which are inclusive;
- evaluating and revising inclusive approaches to curriculum; and
- applying this knowledge and ability in a practical situation.[120]

Based on a review of child care in Alberta, LaGrange et al. recommended that, among other things, caregivers need:

- opportunities to learn about the relationship of culture to the development of young children;
- supportive environments in which to explore issues and solutions; and
- opportunities for critical reflection about beliefs and practices.

To develop necessary skills, practitioners also need experience in planning and implementing programs for children in partnership with families.[121]

The limitations of preservice training and, hence, the importance of continuing education has been noted by several authors, as well as key informants. Limitations of preservice training include:

- **Curricula**: Curricula are being revised to accommodate new research and practice. This work needs to be continued and possibly expanded;[122]
- **Time limitations of practica**: Students do not have the opportunity, nor would it be appropriate for them, to develop relationships with families in a practicuum context;[123]
- **Student attitudes and experience**: Some students enter the field of child care primarily because of their interest in relating to children. As students, they may not be open to the idea of a family-centred focus. After graduation, they have opportunities to appreciate the importance of relating to parents and may find some aspects of this training more meaningful.[124]
- **Lack of models:** Since this is an emerging approach to practice, opportunities for students to spend time in programs modelling this approach are limited.[125]

The reasons listed above, and the dynamic nature of this issue, support the need for continuing education programs, and for opportunities to share ideas and experience with partnership building. The Partnerships Project in British Columbia has developed a training manual for continuing education related to developing partnerships in family support/ family-centred practice. The training provided is intended only as one step in helping practitioners to acquire the knowledge, skills and attitudes for this approach. It needs to be supported by ongoing opportunities for reflection and access to a resource person.[126]

Wolfe and Sykes recommended "more flexible, innovative and meaningful approaches to training and professional development, based on the evaluation feedback in the Health and Diversity project.[127] They suggested a partnership approach to training, referred to as "emergent curriculum,"[128] in which the relevant issues are identified through a dialogue between learners and educators with reference to the environments in which people are working. Both LaGrange et al. and Kwok noted the need for professional development that includes ongoing access to trainers and consultants.[129] Chiu, in her work with multicultural health brokers, emphasized the importance of mentoring and of mutual support in implementing new ways of working.[130]

The interactive parenting program at Merrymount Children's Centre is an example of parents and practitioners learning together. They interact together with the children and discuss their experience. Teachers have "the opportunity to understand and learn about parents and understand the issues they face in their home and community." Parents "have an opportunity to recognize that the staff, other parents and themselves as parents have a wealth of knowledge that each can access, learn from and model for."[131]

Leadership and Infrastructure

Several authors and key informants stressed the importance of supportive environments in building partnerships with families. These environments include leadership, policies, financial resources and resources in the broader community. The following discussion looks at issues of leadership and policies.

Directors play a key role in supporting individual practitioners to take risks and explore new ground.[132] A study of parent–staff communication by Endsley et al.[133] observed that staff behaviour reflected the director's commitment to parental communication. Fear of conflict with parents, fear of not having the answers and making mistakes, and discomfort with new approaches that are incongruent with existing attitudes are strong incentives for practitioners to resist this model. Key informants stressed the need for a safe, non-judgmental environment in which practitioners have the time and feel free to discuss their values, experiences, successes and challenges as they make changes in how they work with parents.[134] Directors are the front line in establishing that safe environment.

Organizations that support family child care providers could play a similar role. However, as with most issues related to training, it is more difficult for the practitioners in family care to find the time and resources to participate in training events and to find support and feedback in their daily work. On the other hand, family care practitioners, by virtue of their direct relationship with families, have a strong, immediate interest in this issue. Trainers in the Partnership Project in British Columbia have found that family care practitioners have responded very positively to the workshop.[135]

Policies are also key components of a supportive infrastructure. They translate philosophy into a concrete commitment to working in partnership with parents. Policies provide a benchmark against which to judge decisions and practices. One key informant noted the importance of policies as reminders of this commitment. They are a way of checking if processes and programs measure up to a group's intentions for parental involvement.[136] At a sector level, standards of practice form the basic statement of policy. They provide a benchmark for developing organizational policies in this area.

Procedures complement policies. In their evaluation of the Diversity and Health project, Wolfe and Sykes[137] noted the importance of clear and coordinated lines of communication. Developing new forms of relationships in a workplace will inevitably place stress on operational systems designed for other ways of doing business. Attention to effective procedures to support operations is a management and leadership function. An example of this was the reorganization undertaken by South East Grey Community Outreach as it redesigned services in response to feedback from parents. The exercise affected all levels of operation, from philosophy to administration.[138]

Practice

While there is considerable research on why it is important to work with parents and the problems inherent in building parent–practitioner partnerships, there is less that evaluates specific strategies for building partnerships or demonstrates concrete links between parental involvement and quality child care. Reports of front-line experience, however, complement the limited research.

Endsley et al.[139] studied the correlations between centre communication with parents, parental involvement and quality. Their conclusion provides some insights, although any generalization must be done with caution since the study was limited to 16 licensed, proprietary child care centres.

Data for the study were collected through director interviews, staff questionnaires and two observation instruments. Formal communication with parents, their participation at the centre and the value that staff placed on communicating with parents were measured. Four components of quality were assessed: health and safety; interactions; space, materials and activities; and home–centre coordination.

There was a positive correlation between "center staff valuing communication with parents and... the extent to which the center uses formal parental communication techniques."[140] Positive correlations were also found between the level of formal communication with parents, parental involvement in the centre and three of the four measures of quality—health and safety, interactions and home–centre coordination. In other words, higher levels of formal

communication, higher levels of parental involvement and higher measures of quality on these scales were associated more frequently than would be likely by chance. Correlations with the measure of quality related to space, materials and activities were positive, but not significant. The study was not designed to determine causality (i.e. whether staff-initiated quality promoted parental involvement, parental involvement was the primary influence on developing quality programs, or they evolved concurrently).

The attitudes, knowledge and skills already discussed help to create the conditions for a program that welcomes parents as partners. Chud[41] summarized the conditions for meaningful parental involvement as follows:

Parents

- feel welcome and comfortable to express their views;
- acknowledge and respect staff expertise and value and appreciate their work; and
- have genuine choice in selecting programs that best match their family need and ability to participate.

Staff

- are open to listening to and acknowledging parents' input;
- acknowledge and respect parents' experience in their primary role as caregivers;
- view their role as a support to families; and
- respect the rights of parents to choose programs that best meet their needs/interests in being involved.

Parents and Staff

- acknowledge that differences in opinions are natural and normal; and
- are committed to problem solving and employ skills that facilitate it.

Building practitioner-family partnerships goes beyond creating a family-friendly environment, but this is an essential building block. The following anecdotes are illustrations of practice from key informants and selected literature:

- Examine how verbal messages and physical space express the message to parents, "You're welcome to be here." Comfortable adult-sized chairs, morning coffee, greetings that recognize parents as persons in their own right, not only as the "parent of," are some ways of sending this message.
- Listen to what parents say about "how" they want to be involved. Parents' priorities may not be the same as staff priorities. Parents at one child care centre were most concerned about a local playground. Support from the child care centre for this concern led to collaboration with other groups in the community to make the playground a safer place. The priority of Vietnamese parents in another centre was to find a space for social dancing.

The child care centre made its space available. This strengthened the community of parents and led to increased participation in other areas more directly linked to the care of the children.[142]

- Recognize that not all parents can/want to be actively involved. Parents have a right to decide not to participate without feeling guilty. South East Grey Community Outreach developed a system of "credits" that acknowledge different levels of participation in helping the work of the centre. The credits are linked to the fee structure.
- Let families plan events for families. Merrymount Children's Centre found that participation in parent information sessions increased when they were organized by parents, even when they had similar topics and speakers.
- Consider family needs when planning events. Timing of events, providing meals, making child care available, making provision for interpretation may all help families to participate.
- Examine all activities for their contribution to building partnerships between staff and families and support for families (e.g. consider how a potluck supper or an information session can be structured to help build supportive relationships among parents). One vision is of a child care centre as "a hub around which programs for parents and families may revolve and through which relationships among parents and between parents and staff members are established and maintained."[143]

These anecdotes illustrate what was reflected in both the literature and the key informant interviews: forming partnerships with parents is reflected not in a specific set of activities, but rather in a set of attitudes and principles that inform and shape all aspects of child care practice.

Resources

Different kinds of resources are important to support the field in moving toward partnership-based, family-centred practice: knowledge resources, including knowledge of how to facilitate change; resources drawn from experience; and financial resources.

Although this is still an emerging area, excellent Canadian work is available in this area reflecting the expertise of many Canadian scholars and practitioners. Many of these can be found in the reference section of this paper, and there are, without doubt, others that have been overlooked. Canadian training manuals, research, evaluations and documentation of experience provide a solid base to learn about issues related to working with families. In 1994, after their review of cultural sensitivity in child care in Alberta, LaGrange et al. commented that the "field seems to lack a clear sense of direction, a framework from which to develop culturally sensitive initiatives, and a common understanding of what culturally sensitive care should look like."[144] As in the early stages of most change, concepts and language are still evolving and need to be clarified. Academics and practitioners need to collaborate to develop conceptual frameworks that can be shared to facilitate discussion of ideas related to partnerships. Emerging theories need to be developed and tested in collaboration with practitioners.

An examination of the theory and processes of change were beyond the scope of this paper. However, this discussion is about making change. Understanding stages of change and how to support organizations and individuals making significant changes is a special kind of knowledge that needs to be more fully integrated into this discussion.

As more family child care homes and child care centres begin to explore and adopt a partnership, family-centred approach to their work, their experience will provide models for and insights into the change process, making it easier for those who follow. Also, some of the human resources for building a family-centred child care practice come from the community of families themselves. Parents are a source of expertise on their own lives—their family, their culture, their neighbourhood.

Financial resources help organizations to gather information and purchase services that help them deal with making changes. When South East Grey began its change process, it had project funds to distribute a questionnaire and hold focus groups across its region to determine what community members, including parents, saw as their most pressing needs.

Finding additional resources was difficult for the child care centres participating in the Health and Diversity project. These centres serve diverse families with many economic challenges. The centres had been relatively isolated from other service providers and were not integrated into the spectrum of resources for families, nor perceived as integral to early intervention initiatives.[145] Project funding helped them come together with other groups and parents to initiate dialogue, but it has been a challenge to maintain the relationships initiated during the project. The limited, short-term funding for the project was insufficient for the groups to consolidate the steps taken. While this process is ongoing, both inadequate funding and lack of time limited the accomplishments of the initial phase. A danger in attempting change with inadequate resources is that participants set goals that are not achievable and they then feel they have failed when their goals cannot be met.

There is a role for mentors, trainers, visionaries, thinkers, creative doers, fundraisers and facilitators to contribute to building and sharing knowledge about parent–practitioner partnerships.

Conclusions

A move to parent–practitioner partnerships in early childhood care and education is well supported in theory, but illusive in practice. Experience is not well documented; research is limited; core concepts are still being clarified. This section summarizes some key assumptions behind this transition and synthesizes key messages that emerge from the diverse literature and experience reviewed for this paper.

It is widely accepted that healthy family–practitioner relationships are a central component of quality child care.[146] However, concepts of "partnerships" and "family-centred" practice go beyond traditional notions of positive, friendly relations. For most practitioners, these terms imply a shift to greater openness to and respect for the knowledge and resources of families. Being open to a plurality of values, beliefs and attitudes, without being judgmental when those values, beliefs and attitudes are significantly different from one's own, is central to the "partnerships" being proposed. Such openness is difficult. To make this shift, individuals need appropriate education and training. They also need safe opportunities to reflect on and learn from their experiences. Organizations also need support and resources to help with the processes of change.

The process of building closer relationships with parents begins with practitioners. Their efforts signal an openness to listening to and working with parents. With this openness, friendly relationships develop into collaborative partnerships as the experience of shared responsibility and reciprocity evolves into mutual trust over time.[147]

Much of the experiential knowledge related to this approach has come from efforts to address diversity in child care settings—diversity of culture, ethnicity and ability. The principles and skills of partnership developed in these situations are designed to respond to the unique circumstances of each family and can be applied to families in other circumstances, since all families are in some way "unique."

Respect for parents includes respect for their right not to participate. The motivation of parents to develop partnerships will, no doubt, vary with their circumstances and individual preferences. Not all parents want to, or are able to, make the commitment to be involved in a "partnership" relationship. Parents need to feel welcomed however they wish to participate, without feeling pressured to be involved beyond their interest or ability.

Powell[148] spoke of this transition happening in parent–practitioner relationships by comparing early childhood programs to a fabric, woven with three different threads—children, parents and staff. Traditionally, the threads of staff and children are closely interwoven, but that of parents is only loosely and intermittently connected in a pattern called "parental involvement." Quality, Powell maintained, improves significantly when the thread of family (both parents and children) becomes an integral part of the tapestry.

Clearly, the tapestry of practitioner–family partnerships is a work in progress. Many of the weavers are still in training. Not everyone is convinced that such a product is feasible. Some initial attempts at realizing the vision, understandably, have flaws. However, for many, the vision of care embodied in this image reflects the future of quality child care.

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Endnotes

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34. Doherty, 1999a, pp. 45-64.
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138. Gott, personal communication; South East Grey Community Outreach, 1998.

139. Endsley, Minish & Zhou, 1993.

140. Ibid., p. 59.

141. Chud, 1992, p. 10.

142. Chiu, personal communication.

143. Weissbourd, 1992, p. 390, in Lamer, 1995, p. 1.

144. LaGrange, Clark & Munroe, 1994, p. 72.

145. Wolfe & Sykes, 1999, p. 31.

146. Doherty, 1999a, p. 33.

147. Kastings, 1992, p. 9; Wilson, 1997, p. 43.

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Regulations as a Strategy for Promoting Quality in Child Care Settings

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Introduction

Provincial/territorial licensing regulations represent the only Canada-wide mechanism for addressing quality assurance in child care. Unlike nursing, child care does not have legislative recognition and thus lacks the legal authority to set and monitor standards through a college of child care practitioners or similar body. Provider certification by a province is only done in Manitoba,[1] although Newfoundland/Labrador will implement it by the end of 1999.[2] Voluntary certification through a professional association only occurs in Alberta, Nova Scotia and Ontario.[3] Unlike the United States, Canada does not have a national voluntary accreditation system for either centre- or family-based child care. Mentoring, which is also used widely on a voluntary basis across the United States, is still in the piloting stage in Canada.[4]

All jurisdictions have requirements pertaining to the physical environment, the protection of children's health and safety, and the permitted number of children per care provider (ratio). Most also regulate group size and specify certain ECCE education requirements for staff in centre-based care (see Appendices B and C). Ratio, group size and care provider ECCE education have been called the "iron triangle" that supports quality in child care centres.[5] Their importance in establishing conditions that increase the likelihood of care provider behaviour that supports and fosters child well-being and development is well-documented.[6] In family child care, ratio and group size are usually the same, except in jurisdictions that permit two providers in a family child care home.[7] The iron triangle for family child care is group size (the permitted number of children), ECCE education and the provision of support to the provider. Again, the importance of each of these three elements for quality is well supported by the research.[8]

One Canadian and two American multi-province/state studies on centre-based care report higher levels of observed quality in jurisdictions that have more stringent limits on ratio and group size and higher requirements for ECCE education.[9] These findings indicate that not only are regulations important but so is their level.

There are three main issues associated with the use of government regulations for quality assurance discussed in this paper:

1. To what extent is it realistic to expect regulations to carry a major burden for the promotion of quality?

2. What are desirable levels of regulation?

3. To what extent do current Canadian child care regulations support and encourage quality?

Limitations of Regulations as a Mechanism for Quality Assurance

Restriction to what is observable or readily checked

Because regulations are attached to a piece of legislation they are legal requirements that can be enforced by law. As a result, they are powerful tools for establishing basic standards such as health and safety provisions in a physical setting. However, the effectiveness of regulations is tied to the ability to enforce them by penalties for non-compliance. This means that it must be possible to document non-compliance and to defend the documentation if challenged. Therefore, regulations have to be limited to what can be observed or easily checked, for example, ratio and staff ECCE education levels. Such limitation means that they are unable to address the type of interaction between the child and the care provider beyond absolute basics such as no corporal punishment. Yet the interaction between care provider and child is probably the most important element of quality once basic health and safety is addressed. Thus the inability of regulations to address this interaction is a major limitation on their ability to encourage quality.

Limits on government ability to monitor regulations

A second limitation relates to the frequency of government monitoring for compliance. What is realistic? What is appropriate? Because of cost it is unrealistic to expect that every child care setting will be visited by a licensing official on even a monthly basis. Nor would it be appropriate. Granting a license to operate implies a belief that the licensee will do no harm. If there is any question about this, the license should not be granted in the first place. Once

licensed, the licensee must be given freedom to operate within the regulated standards without constant government supervision. This is a particularly sensitive issue in family child care where providers are operating in their own homes and are entitled to some privacy. Monitoring visits that are perceived to be too frequent could be interpreted as harassment. Thus while regulations can establish very clear guidelines, the degree to which compliance can be monitored by government officials is limited. Ultimately the extent of compliance with regulations is heavily dependent on self-monitoring.

Difficulties in suspending or revoking a license

Suspension or revocation of the license to operate is the ultimate penalty for non-compliance with regulations. All jurisdictions have the statutory right to suspend or revoke a child care license. However, these provisions are not easy to implement. The concept of due process under the law requires that there be an appeal mechanism. Consequently, most provinces, the Northwest Territories and the Yukon have an appeal board or tribunal in place or a mechanism for the appointment of such a body.[10] Some key informants for this paper noted that their licensing officials are often reluctant to commence the process to suspend or revoke a license. There is uncertainty about what has to be done and how. In most jurisdictions the licensing officials do not have any training in documenting non-compliance. The need for such training has apparently been identified and is being examined by the provincial directors of child care.[11] Other concerns involve the time required to document and re-document instances of non-compliance in order to build a case that can be defended in an appeal hearing. Fear of not being supported in their decision is another issue. Key informants cited situations that had become 'political' when angry parents challenged the government official's position and went to the media. This does not mean that the position was necessarily incorrect. Researchers have noted the discrepancy found between parents' expressed satisfaction with the quality of their children's child care and the level of quality as measured using standard observation tools. This finding has led to the identification of a need for parent education related to indicators of child care quality so that parents know what to look for and demand.[12]

In summary, research supports the value of regulations and the importance of their level. Regulations set the stage that enables the provision of quality. For example, a reasonable number of children per care provider allows the adult to give each child individual attention. However, there are real limitations on their effectiveness as quality assurance mechanisms. This may explain findings of minimal custodial care in licensed centres in two multi-province studies.[13] Regulations cannot stand on their own. They must be supplemented with other approaches, especially approaches that address the interactive aspect of quality. Such approaches include but are not limited to care provider education, parent education, the establishment and dissemination of standards of practice, and mentoring.

Desirable Regulatory Levels

Ratio and group size

Research has clearly documented that each of ratio, group size, ECCE education, and support for family child care providers is important for enhancing quality in child care. However, with few exceptions, the research has not addressed the issue of desirable level. For example, how many children of a particular developmental level is too many for one person to be responsible for? When is a group size too big? One study that did examine the effect of different ratios and group sizes on caregiver behaviour and the provision of developmentally appropriate activities suggests that:

- the upper limit of the ratio associated with desirable practice is 1:3 for children under age 24 months, 1:6 for children age 25 to 36 months, and 1:8 for preschoolers; and
- the upper limit of the group size associated with desirable practice is six children under age 24 months, 12 children age 25 to 36 months, and 18 preschoolers.[14]

On the basis of research and field experience, the Canadian Child Care Federation recommends the ratio and group size levels for centre-based care stated in Table 1, on the following page.

TABLE 1

Desirable adult:child ratios within group size: Centre-based care

Age of children	Group size												
	6	8	10	12	14	16	18	20	22	24	26	28	30
0-12 mths	1:3												
12-24 mths	1:3	1:4											
Two-year-olds		1:4	1:5	1:6									
Three-year-olds			1:5	1:6	1:7								
Four & five year olds						1:8	1:9						
Five & six year olds						1:8	1:9						
6 - 9 years								1:10	1:11	1:12			
10 - 12 years										1:12	1:13	1:14	1:15

Note: Ratios are based on the assumption that the adult has full-time responsibility for the children and is not also required to do administration or provide support services.

Source: Canadian Child Care Federation (1991), *National Statement on Quality Child Care*, p. 9.

The Federation does not provide specific ratios and group sizes for family child care. Instead its *National Statement* says that in a quality situation the provider "ensures that the number and age of the children permits any necessary evacuation."[15] This less restrictive prescription recognizes the multi-age grouping in most family child care homes and the possibility of either one or two providers.

ECCE education

Several studies have found that caregiver behaviours that support child well-being and development are more likely to occur when the adult has post-secondary school ECCE education. This finding holds true for both centre- and family-based child care. The Canadian Child Care Federation states that centre-based providers should have "formal post secondary accredited early children education" but does not stipulate its duration.[16] For centre-based care, the body of research tends to support a two-year rather than a one-year program for entry level practitioners responsible for a group of children and working with minimal supervision..[17]

There is less clarity about the level of desirable formal ECCE education for family child care providers. The Canadian Child Care Federation identifies the desirability of the provider having "an understanding of the developmental needs of children" but does not stipulate how this should be acquired.[18] Three of the seven provincial family child care organizations have produced comprehensive formal training courses.[19] One association ties provider certification to successful completion of the course.[20] The findings of the National Family Day Care Training Project also support the importance of formal training.[21] While there appears to be a growing consensus that some type of training is desirable, many questions are unanswered. For example, should some basic training be required before starting child care provision? What is the key content that should be covered? What are the best ways to deliver training?

Support for family child care providers

Research indicates that quality is more likely when the family child care provider has some mechanism for regular, on-going support.[22] This might be through an agency home visitor, participation in family resource program activities, and/or involvement in a provider network. However, the research provides virtually no guidance in regard to desirable levels or frequencies of support other than more is generally better than less.

Extent to which Canadian Regulations Support Quality

Ratio

Centres

All the provinces, the Northwest Territories and the Yukon have regulations stipulating permitted ratio levels in centre-based care. All also set a limit on the permitted number of children in regulated family child care (where ratio and group size is usually the same). The current regulations for both centre- and family-based care are provided in Appendices B and C respectively.

The regulations in every province and territory fall short of completely meeting the ratio levels recommended by the Canadian Child Care Federation. In the case of preschool-age children, when ratio requirements do not meet the recommended level they are generally off by one child. For example, British Columbia, Nova Scotia and the Yukon permit a ratio of 1:4 for children age 0 - 18 months instead of the 1:3 recommended for children under age 12 months. The research cited at the beginning of this section suggests that being off by one child may not be compatible with best practice.

The situation in Québec is definitely a concern. Québec permits a ratio of 1:5 for children under age 18 months and a ratio of 1:8 for children age 18 months to 36 months. Five infants and toddlers, or eight two-and three-year-olds, represent an extremely demanding workload for one person. A workload that could be expected to be stressful and encourage staff turnover. Research has found that too many children per care provider is associated with restrictiveness towards the children.[23] Restrictiveness, in turn, is associated with poorer language development[24] and poorer performance on tests of cognitive functioning.[25] Very young children are either completely or heavily dependent on the care provider to meet their basic physical needs. Québec's permitted ratios would make it difficult for the adult to attend to children's basic needs and also find time to provide them with linguistic or cognitive stimulation through games and other activities. Thus the Québec ratios for children under age 36 months pose a definite threat to quality. The permitted Québec ratios for four- and five-year-olds is 1:10 with a permitted group size of 30. These regulations also allow ratio and group size to exceed the levels recommended by experts.

By September 1999, two-thirds of all staff in a Québec centre will be required to have a college diploma or university degree in ECCE.[26] In France, a ratio of 1:28 is permitted for three- to six-year-olds though in practice it is usually 1:22.[27] Furthermore, unlike Canada, only the teacher is counted in the ratio, not the teacher and her assistant. Nevertheless, even a ratio of about 1:14 is higher than recommended by the Canadian Child Care Federation. Yet visiting American early childhood experts rate these programs as being high quality.[28] The ability to provide a quality experience in spite of a large group of children has been attributed to the high levels of staff training. This may be partly true. A recent Canadian study compared process quality in kindergarten and child care rooms serving the same-aged children. It reports that the kindergarten teachers all had higher education levels and generally quality was higher in the kindergartens even though there were more children per staff.[29] However, while a higher level of ECCE education might compensate for a larger number of four- and five-year-olds, it is much less able to do so with younger children because of their dependence on the adult to meet their basic needs. Meeting these needs takes time, regardless of the adult's educational level. Therefore, the number of children must be kept low if the care provider is to do anything more than simply provide custodial care.

Family child care

Ratio and group size are usually the same in family child care, except in Manitoba, Québec and the Yukon where there are provisions for homes to have two providers. All jurisdictions except Nova Scotia, limit the number of permitted children under age two or under age three. In most cases, the upper limit is two children of this age. The notable exception is the Yukon which permits four infants. It is difficult to imagine one person being able to evacuate four infants and some preschoolers in the case of an emergency. Thus, the Yukon regulations potentially put children's safety at risk. Manitoba, the Northwest Territories, Saskatchewan and the Yukon all permit up to eight children in a mixed-age group, including the provider's own. Again, depending on the age mix, responsibility for eight young children may be more

than is compatible with ensuring their safety. Even if safety is ensured, quality may not be. In a situation of eight children under age six, which could occur in the Yukon, the care provider would be hard pressed to find time for sensitive personalized interactions with each child and the provision of individualized, developmentally appropriate activities.

Group size

The regulations in every province and territory fall short of completely meeting the group sizes for centres suggested by the Canadian Child Care Federation. Nova Scotia does not specify group size and Prince Edward Island only does so for children 0 - 2 years. In some provinces group sizes are significantly larger than those recommended. For example, Saskatchewan allows a group size of 20 for children age 30 months to 6 years while British Columbia allows up to 25 and Québec up to 30 for this age range. Large group size is not an issue of basic safety if the staff to child ratio is reasonable. However, there are quality implications. The adults are more likely to be restrictive and the program to be regimented when there is a large group of children.[30]

ECCE education

Centres

No jurisdiction meets the desirable level of a two-year post-secondary school ECCE credential for all people working with preschool age children in a centre. An acceptable alternative would be a requirement that one person in every group of children have a two-year ECCE credential. The assumption being that this person would provide on-going supervision for any less trained provider also working with the children. Only Manitoba and Ontario have this requirement.

The regulations in Alberta, British Columbia, Newfoundland and Saskatchewan do require a person with some training with each group, though with a lower level of education. In British Columbia the level is at least a 10-month community college certificate. Newfoundland

requires a one-year certificate. Alberta and Saskatchewan require all providers to have completed an ECCE orientation of 50 or 130 hours respectively unless they have an ECCE certificate or equivalent. This translates into a person with at least a minimal amount of training with each group of children. Québec and Nova Scotia require two-thirds of the staff working with preschool age children to have community college ECCE training. In the Yukon, by the year 2000, 30% of staff must have a certificate and an additional 20% must have a diploma.

The provisions in these three jurisdictions make it highly likely that there will be a trained person with each group, but fall short of requiring it. Therefore, a group of children could be cared for solely by untrained people. Most skilled jobs, for example nursing, assume that certain knowledge and skills are necessary for competent practice. Therefore, they require potential practitioners to have specific education before beginning to work in the field. The provision of a safe, quality child care program also requires a knowledge base and specific skills.[31] As a result, pre-service training is necessary to increase the likelihood that the adult will provide an experience that fosters the child's well-being and development.

New Brunswick[32] and the Northwest Territories do not have any educational requirements. Prince Edward Island only requires the supervisor and one staff person to have a diploma, even though it permits centres to have as many as 50 spaces. Again this means that groups of children could be cared for solely by untrained people.

No jurisdiction requires specific age-appropriate training for the provision of school-age care and only British Columbia requires people working with infants and toddlers to have taken specialized infant/toddler training. A telephone survey of 52 key child care researchers and academics across the United States and Canada found almost a consensus that adults looking after infants and children in a group setting require specific training related to this age group.[33] It also found widespread agreement that staff in programs for children over age six require specific training. This training must focus on child development between ages six and 12 and identification of the differences in developmental tasks and issues across this age group. The importance of specialized training related to working with infants/toddlers or with school-aged children has been noted by several other researchers and policy analysts.[34]

British Columbia requires one person with training related to children who have special needs, in addition to a basic ECCE credential, for every four children with special needs in centre-based care. Ontario has the same requirement. No other jurisdiction recognizes the need for specialized education related to working with handicapped children even though integration of children with special needs is a policy in most provinces and the territories. This lack of requirement jeopardizes true inclusion. It reduces the likelihood that the child care provider will have the knowledge and skills required to adapt programs and materials appropriately to meet the child's special needs.

No jurisdiction requires a centre supervisor or director to have specialized education in management, supervision or administration. New Brunswick and the Yukon do not have training requirements for any staff position. In other provinces, such as Newfoundland, Nova Scotia and Prince Edward Island, a centre director only requires a one-year ECCE credential. Sixty-seven percent of 900 American centre directors responding to a questionnaire about desirable qualifications stated that courses in administration should be a pre-requisite to assuming the position of director.[35] This opinion acknowledges that the director acts as a "gatekeeper to quality" who sets the standards and expectations for others to follow.[36] Through this, she influences the development of the centre as a nurturing and educational environment for children and a pleasant place in which to work for staff.

Only two jurisdictions, British Columbia and Prince Edward Island, require qualified centre-based caregivers to participate in on-going professional development. In both cases this requirement is tied to renewal of a certificate or license to practice. In the other jurisdictions there is no government mechanism to encourage child care practitioners to keep up-to-date with new research findings or changes in the definition of what constitutes best practice.

In summary, only two jurisdictions meet the acceptable level of requiring one person with at least a two-year ECCE certificate with every group of children in a child care centre. In practice, the Québec requirement that two-thirds of the staff have this level of training probably means that most groups have one person with this credential. However, it does not guarantee it. Children in other jurisdictions are looked after by people with lower levels of training or no training at all. This has to be a concern. Lack of ECCE education increases the likelihood that the caregiver will provide experiences that are not developmentally appropriate and/or have expectations of the children that are not appropriate for their developmental stage.

Thus, with the exception of three provinces, the current regulations pertaining to staff ECCE education do not support quality child care provision. Failure to support quality is also exhibited in the lack of requirements for specialized training to work with infants and toddlers, school-age children, and children with special needs. Similarly, failure to require special training for centre directors means that people can assume this position with no understanding of its unique demands nor the knowledge to meet them.

Family child care providers

ECCE training for regulated family child care providers is only required by Prince Edward Island, Québec, Saskatchewan and the Yukon. Newfoundland intends to make it mandatory.[37] The highest requirement is in the Yukon where all regulated family child care providers must complete a 60-hour ECCE course within the first year of providing care. At the other end of the spectrum, Saskatchewan has a policy that family child care providers should take two professional development workshops a year. The discrepancy in ECCE education

requirements between regulated providers in centres and homes defies logic given that many of the needs of the children are the same regardless of the setting. There is also some modest support for the notion that training related to child care provision improves quality in family child care.[38] Furthermore, it could be argued that family child care providers are more in need of training than are centre-based providers because they generally work alone. The current level required, or in many situations the lack of any requirements, therefore must be identified as failing to support quality.

Support for family child care providers

Provincial/territorial governments address the issue of support for regulated family child care providers in three different ways. In Alberta, Nova Scotia, Ontario and Québec it is done by linking the providers with an agency. Newfoundland intends to allow regulated providers to either link with an agency or be independently licensed.[39] In three of the provinces with an existing agency model, the agency is required to visit the home at least four times a year. It is also expected to maintain a mechanism that enables providers to contact the agency when they need advice or assistance. In Alberta, the requirements on agencies are not statutory. As a result, while requiring home visits has been government policy they may not be required when responsibility for child care is transferred to the 18 regional children's authorities later in 1999.

The intent of home visits is to provide a knowledgeable person who forms an ongoing relationship with the caregiver and can be a source of advice. Theoretically, this mechanism should be an effective way of providing support. The home visitors in Ontario and Québec, and two-thirds of them in Nova Scotia, are required to have ECCE education **or** experience working with young children, though not necessarily in child care. Their ability to provide support would be better ensured if all were required to have both a formal ECCE post-secondary school credential and experience in child care. The potential effectiveness of the home visitor as a support is also reduced by including responsibility for monitoring as part of the role. Monitoring for compliance with government regulations and agency policies is an attempt to ensure quality. However, as noted earlier, monitoring by an outside person can only be done on a periodic basis. Therefore, the agency has to rely on the provider's self-regulation. The home visitor's policing role may lessen the extent to which a provider is willing to seek assistance when unsure of what to do or is experiencing difficulties. In all four provinces with agencies in place at least some of them provide a range of other supports such as regular meetings with other providers or training. However, the provision of such supports is not required by the regulations.

British Columbia has taken a different route to attempting to ensure that regulated family child care providers have access to on-going support services. It has established a network of Child Care Resource and Referral Programs with a mandate to provide a range of support services such a toy and equipment lending and provider drop-in programs. A similar type of support is available to family child care providers in many parts of Ontario through its network of Family

Resource Programs. This approach deals with the conflict inherent in one person having both a policing and a support role. However, unlike the agency situation, there is no statutory requirement to provide support to a certain group of family child care providers.

The only government support in the other provinces and the territories is provided through visits from licensing officials. The required frequency of these varies from four or five in the Yukon and four in Manitoba to the more general annual visit. The extent to which these visits can actually be supportive is limited in two ways. First of all, the licensing official is not required to have an early childhood background in Prince Edward Island or Saskatchewan, though in practice most do. People who do not have this type of background would be less knowledgeable about child care or the issues that a provider might face. Secondly, the licensing officials, by the nature of their job, have a policing role. As noted above, the inherent conflict in this dual role may reduce the extent to which the person is perceived to be a source of support.

In summary, current regulations fail to provide many regulated family child care providers with a either a knowledgeable source of advice or a range of other support services.

Are requirements statutory or policy?

The general assumption is that requirements related to ratio, group size, permitted number in family child homes, care provider training, and family child care agency responsibilities are regulations tied to legislation and therefore have the force of law. However, in Nova Scotia the permitted ratio for infants and the permitted number of children in family child care homes are policies, not regulations.[40] The whole family child care program in Alberta operates as an exemption under the *Social Care Facilities Licensing Act*.[41] When requirements are policy rather than statutory they are easy to change without any public debate and more difficult to enforce. As a result, they loose some of their power as quality assurance tools.

Conclusions

Regulations are an important tool in quality assurance. However, it is ineffective and inappropriate to rely on them as the primary mechanism. By their very nature they have inherent limitations. While all jurisdictions have specific requirements related to ratio, group size and the permitted number of children in family child care, none completely comply with the recommendations of child care experts. In particular, requirements for ECCE training fall significantly short of what is needed to support quality.

Endnotes

1. British Columbia requires government credentialing for supervisors, but not for other staff.
2. Helen Sinclair, Department of Health and Community Services, personal communication, May 3, 1999.
3. Doherty, *Credentialing as a strategy for promoting quality in child care*, 2000.
4. Pilot projects have been conducted in British Columbia, Newfoundland, Nova Scotia and Ontario.
5. Hayes, Palmer & Zaslow, 1990, p. 87.
6. Doherty, *Elements of Quality*, 1999, Chapter 1.
7. Manitoba, Québec and the Yukon permit two providers and, in this situation, a larger number of children than permitted if there is only one provider.
8. Doherty, *Elements of Quality*, 1999, pp 12-13 and 34-35.
9. Doherty and Stuart, 1996; Helburn, 1995; Whitebook, Howes and Phillips, 1990.
10. Childcare Resource and Research Unit (2000).
11. Kathleen Flanagan Rochon, personal communication.
12. Shinn, Phillips, Howes, Galinsky & Whitebook, 1989, pp. 23-24.
13. The findings in question were scores of three or less on the *Infant/Toddler Environment Rating Scale* or the *Early Childhood Environment Rating Scale* by Doherty and Stuart, 1996, pp. 14 and 16, and by Lyon and Canning, 1995, p. 39.
14. Howes, Phillips and Whitebook, 1992, pp 455-456.
15. Canadian Child Care Federation, 1991, p. 25.
16. Op. Cit., p. 3.
17. Goelman, 1999.
18. Op. Cit., p. 19.
19. Alberta Association for Family Day Home Services, Western Canada Family Day Care Association (B.C.), and the Family Day Care Association of Manitoba (which subsequently amalgamated with the Manitoba Child Care Association).
20. Alberta Association for Family Day Home Services.
21. National Family Day Care Training Project, 1998, pp. 18-22.
22. Doherty, *Elements of Quality*, 1999, pp. 34-35.
23. Howes, 1983; Howes & Rubenstein, 1985; Whitebook, Howes & Phillips, 1990.
24. Berk, 1985; Bryant, Peisner-Feinberg & Clifford, 1993; Carew, 1980; McCartney, 1984.
25. Clarke-Stewart, 1987.
26. Recent provincial government pronouncements suggest that implementation of this requirement may be delayed. Jocelyne Tougas, personal communication, May 11, 1999.
27. Howes & Marx, 1992, p. 354.
28. Ibid., p. 364.
29. Johnson & Mathien, 1998, p. 38.
30. Doherty, *Elements of Quality*, 1999, p. 10.
31. Canadian Child Care Federation, *Standards of Practice for Practitioners in Child Care Settings*, (2000).
32. By 2003, either the director or her designate in a New Brunswick centre, or one staff in four will have to have a one-year ECCE credential. It should be noted that this is an either-or situation. If the director or designate has the credential no staff will be required to have it. If one out of four staff people have a one-year ECCE certificate, the director or designate will not be required to have ECCE training (Dianne Lutes, personal communication, November 16, 2000).
33. Doherty, 1991, p. 36.
34. Alexander, 1986; Kulken, 1985; Seligson & Fink, 1989; Whitebook, Howes & Phillips, 1990.
35. Jorde-Bloom, 1989.
36. Jorde-Bloom, 1992, p. 142.
37. Helen Sinclair, personal communication, April 30, 1999.
38. National Family Day Care Training Project, 1998, pp. 3-5.
39. Helen Sinclair, personal communication, April 30, 1999.
40. Sherry Ridgewell, personal communication, May 3, 1999.
41. Deborah Laundry, personal communication, May 3, 1999.

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Appendix A

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Appendix B

OVERVIEW OF CENTRE CHILD CARE REQUIREMENTS BY JURISDICTION, 1999

Appendix B - 1

Jurisdiction	Variable	Requirements
British Columbia	Ratio and group size	**Ratio** / **Group size** 0 - 3 years 1:4 12 30 months - 6 years 1:8 25 half-day preschool 1:10 20 school-age 1:10 - 15 20 - 25 (depending on age) **Maximum centre size**: not specified
	Training requirements	Under age 30 months: Each group of 5 - 8 children requires one infant-toddler educator (basic 10 month ECCE program plus specialized infant/toddler training) and one early childhood educator (at least 10 months ECCE program from approved institution). Each group of 9 - 12 children requires one infant-toddler educator, one early childhood educator and one assistant. Thirty months to school age: Each group requires one early childhood educator plus assistants. School age: Staff must have taken a course on the care of young children or have relevant experience
	Monitoring	License is not time-limited. Practice is to do a monitoring visit each year, but this is not a legislative requirement. Inspectors are not required to have an early childhood education background.
Alberta	Ratio and group size	**Ratio** / **Group size** 0 - 12 months 1:3 6 13 - 19 months 1:4 8 19 - 35 months 1:6 12 3 - 5 years 1:8 16 5 - 6 years 1:10 20 school-age - operated by municipalities that set own standards **Maximum centre size**: 80 spaces
	Training requirements	Directors required to have a two-year college diploma in ECCE or equivalent. One in four staff required to have one-year ECCE college certificate or equivalent. All other child care staff required to have a 50 hour child care orientation course delivered through a community college or equivalent
	Monitoring	Responsibility for licensing and monitoring is being transferred to 18 regional children's authorities. Practice has been quarterly licensing visits by licensing officers but this is not required by legislation and may change after the transfer. Licensing officers not required to have an ECCE background.

Appendix B - 2

Jurisdiction	Variable	Requirements
Saskatchewan	Ratio and group size	**Ratio** — **Group size** Infants 1:3 — 6 Toddlers 1:5 — 10 30 months - 6 years 1:10 — 20 6 - 12 years 1:15 — 30 **Maximum centre size**: 90 spaces
	Training requirements	Supervisor must have one-year ECCE certificate or equivalent. Every staff member must take a 130-hour child care orientation course or equivalent provided through community college within one year of commencing work unless the person has a one-year ECCE certificate or equivalent.
	Monitoring	A minimum of three visits annually (policy, not statutory). Provincial program consultants are not required to have a background in early childhood education.
Manitoba	Ratio and group size	**Mixed age- groups - ratio** — **Group size** 12 weeks - 2 years 1:4 — 8 2 - 6 years 1:8 — 16 6 - 12 years 1:15 — 30 **Separate age-group -ratio** — **Group size** 12 weeks - one year 1:3 — 6 1 - 2 years 1:4 — 8 2 - 3 years 1:6 — 12 3 - 4 years 1:8 — 16 5 - 6 years 1:10 — 20 6 - 12 years 1:15 — 30 **Maximum centre size**: 70 spaces
	Training requirements	A centre director must be an ECE III (have completed an approved ECE III program or recognized certificate program or approved university degree) and one years' experience working in child care or a related field. Two-thirds of staff caring for preschoolers must have an ECE II (an approved diploma in child care from a community college or satisfactory completion of the Child Day Care Competency Based Assessment or an ECE III (described above). There is a regulatory requirement for one ECE II or ECE III with each group of preschool-age children. One half of staff employed in a school-age program or a nursery school must be classified as an ECE II or III.
	Monitoring	Minimum of three visits each year, one of which is a re-licensing visit (policy, not regulations). Licensing staff required to be an ECE III with experience in child care

Appendix B - 3

Jurisdiction	Variable	Requirements
Ontario	Ratio and group size	**Ratio** / **Group size** birth - 18 months 3:10 10 18 months - 2.5 years 1:5 15 2.5 - 5 years 1:8 16 5 - 6 years 1:12 24 6 - 10 years 1:15 30 **Maximum centre size**: Not specified
	Training requirements	Supervisors must have a two-year ECE diploma or equivalent and at least 2 years' experience working in child care. One staff person with each group must have a two-year ECE diploma or equivalent. A Ministry director can waive the educational requirements for supervisors or staff.
	Monitoring	Annual licensing inspection (policy, not statutory requirement), additional unannounced drop-in visits may also be done. Program Advisors are not required to have an early childhood education background, practice is to hire people with a background in child development, teaching or related field.
Québec	Ratio and group size	**Ratio** / **Group size** 0 - 18 months 1:5 15 18 months - 3 years 1:8 30 4 - 5 years 1: 10 30 6 - 12 years 1: 15 30 **Maximum centre size**: 80
	Training requirements	Two-thirds of all staff must have a college diploma or university degree in ECCE.
	Monitoring	Permits (licenses) for centres serving preschoolers issued for two years, no license required for for school-age care provided on school premises. No regulatory requirement for the frequency of visits by provincial officials, nor are they required to have a background in early childhood education

Apprendix B - 4

Jurisdiction	Variable	Requirements
New Brunswick	Ratio and group size	**Ratio** / **Group size** Less than age 2 — 1:3 — 9 2 - 3 years — 1:5 — 10 3 - 4 years — 1:7 — 14 4 - 5 years — 1:10 — 20 5 - 6 years — 1:12 — 24 6 - 12 years — 1:15 — 30 **Maximum centre size**: 60 spaces
	Training requirements	No early childhood education training or experience required.*
	Monitoring	One annual inspection is a statutory requirement, also conduct up to three unannounced visits per year. Government regional coordinators required to have a B.A. in child studies, ECE diploma or related qualification
Nova Scotia	Ratio and group size	**Ratio** / **Group size** 0 - 17 months — 1:4 — Not specified 17 months - 5 years — 1:7 — Not specified (full day) 17 months - 5 years — 1:12 — Not specified 5 - 12 years — 1:15 — Not specified Maximum centre size: 60 spaces
	Training requirements	Centre director and 2/3 of staff must have either a one- or two-year ECCE certificate or diploma or two years experience, one ECCE course and a 35-hour workshop on child development and curriculum (regulation)
	Monitoring	Annual inspections by licensing staff (policy, not statutory) who are not required to have a background in early childhood eduction but are provided with annual early childhood training

* By the end of fiscal year 2003, the director or designate or 1 4 staff must have a one-year ECCE credential (Diane Lutes, personal communication, November 16, 2000). Note this is either/or, thus if the director has the credential it is not a requirement for any of the staff.

Appendix B - 5

Jurisdiction	Variable	Requirements
Prince Edward Island	Ratio and group size	**Ratio** / **Group size** 0 - 2 years: 1:3 / 6 2 - 3 years: 1:5 / Not specified 3 - 5 years: 1:10 / Not specified 5 - 6 years: 1: 12 / Not specified seven years and up: 1:15 / Not specified **Maximum centre size**: 50 spaces
	Training requirements	Supervisor and one full-time staff person in each program must have at least a one-year ECCE diploma or a university child study degree. Thirty hours of in-service training every three years is required for all staff.
	Monitoring	Yearly licensing visit by a government official who is not required to have an early childhood education background.
Newfoundland/ Labrador	Ratio and group size	**Ratio** / **Group size** under age one: 1:3** / 6** 2 - 3 years: 1:5** / 10** 3 - 6 years: 1:8 / 25 7 - 12 years: 1:15 / 25 **Maximum centre size**: 50 spaces
	Training requirements	Supervisor must have either a one-year ECCE certificate and one year's experience or a two-year ECCE diploma (with no requirement for experience). Supervisors appointed prior to 1989 are not required to have these qualifications. By the end of 1999, will require one staff member in each group must have a minimum of one-year ECCE certificate (to be a statutory requirement)**
	Monitoring	Licenses are renewed for periods of up to three years. One monitoring visit every six months is a statutory requirement. Government licensing officers do not have to have an early childhood background but the government is hiring people with ECCE credentials to work in each of the four regions and to provide consultation to the licensing officials and child care providers.**

** Effective in 1999. Helen Sinclair, personal communication, April 30, 1999.

Appendix B - 6

Jurisdiction	Variable	Requirements
Yukon	Ratio and group size	**Ratio** / **Group size** 0 - 18 months 1:4 8 18 months - 3 years 1:6 12 3 - 6 years 1:8 16 6 - 12 years 1:12 24 Maximum centre size - 64 spaces
	Training requirements	By September 1999, 50% of the regular staff must have completed a 60-hour ECCE introduction course or equivalent and 30% must have completed a one-year ECCE certificate course or equivalent. By 2000, 20% of the staff must have two years training in early childhood education or equivalent.***
	Monitoring	One annual licensing inspection visit (statutory) and, in practice, three - five unannounced visits. Government licensing officials are required to have a background in early childhood education
Northwest Territories	Ratio and groupsize	**Ratio** / **Group size** birth - 12 months 1:3 6 13 - 24 months 1:4 8 25 - 35 months 1:6 12 three years 1:8 16 four years 1:9 18 5 - 11 years 1:10 20 **Maximum centre size** - Not specified
	Training requirements	No ECCE training requirements
	Monitoring	License granted for between three and five years. Annual inspections are a regulatory requirement and conducted by a program officer who is required to have a background in early childhood education

*** Debbie Mauch, personal communication, May 5, 1999.

Appendix C

OVERVIEW OF FAMILY CHILD CARE REQUIREMENTS BY JURISDICTION, 1999

Appendix C-1

Jurisdiction	Variable	Unregulated	Regulated
British Columbia	Permitted numbers	No more than two children unrelated by blood or marriage, excluding the provider's own	Up to 7, including the provider's own. No more than 5 preschoolers, three under age 3 or one under age 1.
	Educational requirements		Must have a first aid certificate, no ECCE training requirements
	Formal provisions for support	Network of child care support programs which have a mandate to provide support to the unregulated sector ("license not required").	Annual licensing visit (policy, not statutory equirement) by a licensing official who is not required to have an ECCE background. Network of child care support programs
Alberta	Permitted numbers	No more than 6 children under age 11, including the provider's own. Maximum of three under age 2	No more than 6 children under age 11, including the provider's own. Maximum of three under age 2 and two under age 2
	Educational requirements		None
	Formal provisions for support		Providers connected with an agency that is expected to visit once a month (this is not a statutory requirement and may change with the transfer to regional children's authorities in 1999). Home visitor not required to have ECCE background. Agency expected, but not required, to provide support services.
Sask.	Permitted numbers	No more than 8, including the provider's own under age 13	No more than 8, including the provider's own under age 13. No more than five under age 6, of these, only two can be under age 30 months
	Educational requirements		Must have first aid certificate, expected to attend two professional development workshops each licensing year (policy, not regulation)
	Formal provisions for support		Minimum of three visits a year by a government program consultant (policy, not statutory) who does not have to have an ECCE background.

Appendix C - 2

Jurisdiction	Variable	Unregulated	Regulated
Manitoba	Permitted numbers	No more than 4, including the provider's own. Maximum of two children under age 2	No more than 8, including the provider's own under age 12. Maximum of five children under age 6 and three children under age 2. With two providers: no more than 12 children under age 12, including the providers' own, no more than 3 may be under age 2
	Educational requirements		Must have a valid first aid certificate that includes CPR training relevant to the group being cared for. No ECCE training requirements
	Formal provisions for support		Minimum of one licensing and three drop-in visits per year (policy, not statutory) by a government licensing official who must have an ECE III and child care experience
Ontario	Permitted numbers	No more than 5, excluding the provider's own	No more than 5, including the provider's own. Not more than two may be under age 2, not more than three under age 3.
	Educational requirements		If working with handicapped children, must have a first aid certificate. No ECCE training requirements
	Formal provision for support	200 family resource programs funded by the Child Care Branch with a mandate to provide support services to un-regulated providers	Providers connected with an agency that is required by legislation to provide quarterly home visits. Home visitors must have an ECCE-related post-secondary program and at least two years' experience working with children. Regulatory requirement that agencies have a training plan for each provider but no requirement for type, frequency or length of training provided. Network of family resource programs
Québec	Permitted numbers	No more than 6, including the provider's own	No more than 6, including the provider's own under age 12. No more than two under age 18 months. With two providers: No more than 9, including the providers' own. No more than four under 18 months
	Educational requirements		First aid certificate within six months of starting to provide care and completion of a 45 hour ECCE training program within the first two years . A minimum of six hours professional development each year.
	Formal provision for support		Providers connected with an agency that must do quarterly home visits. Home visitors are not required to have an ECCE qualification but must have three years' experience in direct services for children. Agencies expected to provide some training and support services

Appendix C - 3

Jurisdiction	Variable	Unregulated	Regulated
New Brunswick	Permitted numbers	No more than five, including the provider's own under age 12. Maximum of two infants, maximum of 4 if children are age 2 - 5	No more than six children age 0 - 12, including the provider's own. No more than three under age 2, or five between age 2-5. May have nine children, including own, if all of them are over age 6
	Educational requirements		Must have first aid training, no ECCE training requirements
	Formal provision for support		Statutory requirement for an annual licensing visit and spot checks by provincial licensing officals who are required to have a B.A. in child studies, ECE diploma or related qualification
Nova Scotia	Permitted numbers	No more than six under school age, including the provider's own. May have 8 if all, including the provider's own, are school age	No more than six under school age, including the provider's own. May have 8 if all, including the provider's own, are school age.
	Educational requirements		None before starting to provide care. Required to attend 4 hours of ECE workshops each year.
	Formal provision for support	Child Care Connections NS, in Halifax provides training and support to caregivers in its area	Providers connected with an agency that must do two home visits each month (policy, not statutory). Two-thirds of the home visitors in an agency must have a two-year ECCE diploma, or an ECCE certificate and experience (regulation). Agency required to provide 10 hours of workshops a year.
Prince Edward Island	Permitted numbers	No more than 6 in a mixed-age group up to age 10, with maximum of two under age 2. If all children are under age 2, maximum of three, maximum of five preschoolers with no more than two under age 2. All numbers include provider's own preschool children	No more than seven children, including the provider's own under age 12. Maximum of three children under age two.
	Educational requirements		30-hour ECCE training program within the first year of providing care
	Formal provision for support		Annual licensing inspection by a government official (policy, not statutory) who is not required to have a background in early childhood education.

Appendix C - 4

Jurisdiction	Variable	Unregulated	Regulated
Newfoundland/ Labrador	Permitted numbers	No more than four, including the provider's own	No more than six mixed age including the provider's own under age 6. Maximum of three under age 3 or two under age 2, if all children are under age two, maximum of three
	Educational requirements		First aid certificate. Must complete an orientation course in early childhood education within the first year of providing care.
	Formal provision for support		Providers can either be linked with an agency or independently licensed. The agency is required to do an annual monitoring visit and additional monthly visits. Home visitors must have an ECCE background. Independently licensed providers receive annual licensing visits and several other un-scheduled home visits per year by government consultants. Government licensing officials are not required to have an ECCE background.
Yukon	Permitted numbers	No more than three, excluding the provider's own	No more than eight, including the provider's own under age six. Maximum of four infants, or no more than six pre-school children with a maximum of three infants. With two providers: may add four school-age children
	Educational requirements		First aid certificate. Completion of a 60-hour early childhood education course, family day care course or equivalent within the first year of providing care (policy, not regulation)
	Formal provision for support		Policy of one annual inspection and four or five unannounced spot checks per year by a government Child Care Coordinator who is required to have a background in early childhood education

Appendix C - 5

	Variable	Unregulated	Regulated
Northwest Territories	Permitted numbers	No more than four, including the provider's own under age 12	No more than eight, including the provider's own under age 12. Maximum of six age 5 or under, maximum of three under age 3, and maximum of two under age 2
	Educational requirements		First aid certificate. No early childhood training requirements
	Formal provisions for support		Annual visits by a government program officer who is required to have a two-year ECCE diploma and four years child care experience (both statutory requirements)

Literature Review of Training and Family Day Care

by David Boisvert

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Abstract

This paper reviews some of the most important English-language academic and professional literature dealing with the issue of training and family day care. It seeks to identify what the literature reveals about the need for, implementation and design of family day care training programs. To keep the paper within manageable limits, only sources that deal directly with the issue of training were examined. The focus is primarily on Canadian, British and American sources since these have the most bearing on the situation of family day care providers in Canada.

It should be noted that I have taken a critical approach to reviewing the available literature. The literature captures the views of the acknowledged experts in the field, but we should be under no illusion that these necessarily reflect the views of caregivers themselves. And though academics and professionals generally agree on the need for training programs in this field, their support for training programs often has less to do with the results of their own studies and observations than with a widely-shared (in academic circles at least) and largely unstated commitment to change the character of family day care. It is important therefore to point to the major assumptions made by those who write and publish in this field, and to identify not only the stated results of the various studies that have been carried out, but to take a critical look at their methodology and the practical import of their conclusions for family day care providers.

The literature provides two major rationales for providing training programs to caregivers:

1. *to improve the quality of child care; and*
2. *to enhance the professional status of caregiving and of child care providers.*

This paper first reviews the general thrusts of these two arguments for training programs made in the literature. It then examines the basis of these arguments in more detail, in

particular, the measures used to determine child care quality and how they have been applied to evaluate family day care. I conclude by examining what the literature tells us about the issues that have to be addressed in the design and delivery of training programs to caregivers.

Training and the Quality of Child Care

In discussing the evolution of academic thinking on day care in North America, Pence and Goelman note how the focus of discussion shifted from an initial concern in the 1960s and 1970s with the issue of whether day care was in itself a good or bad thing to concerns with the "quality of child care."[1] This shift in focus can be imputed to an acknowledgment that child care was here to stay — the phenomenon was irreversible no matter whether day care was judged to be good or bad — and to the realization that there is in any event no black and white answer to this question.[2] It appeared much more productive to concentrate on identifying the conditions that make for "good" child care. By the mid 1990s, this had given rise to a considerable literature on the factors that are conducive to good quality child care, on the measurement of child care quality in both family- and centre-based settings, and on alternative ways to maintain and promote higher quality care.[3]

It is in this context that the literature begins to take a growing interest in the training of family child care providers. Training came to be seen as a way to improve what many considered the poor quality of child care offered in family day care homes. Some of the earliest studies of family day care arrangements had in fact challenged the view that family day care arrangements were synonymous with poor quality care,[4] but by the mid-1980s most researchers in the field were convinced that the weight of evidence was in the opposite direction. The evidence upon which they relied were a limited number of studies reputedly showing that conditions in the majority of family day care homes were detrimental to a child's development[5] and a growing body of literature associating caregiver education/training levels with the quality of child care.[6] Along with calls for greater regulation of the family day care sector, training of day care providers was soon identified as one of the most promising means to improve the quality of care given to children in home day care. By 1987, Phillips and Howes were writing in summarizing research results up to that time that "there is ample evidence that specialized training is associated with good quality care,"[7] a conclusion reiterated by Kontos in a literature review conducted several years later.[8]

It is important to understand that this association of training with higher quality child care was based almost exclusively on a positive correlation that several child care studies have found between the educational background/characteristics of caregivers and a number of quality indicators. For example, Ruopp et al. had found in the American National Day Care Study

conducted in the late 1970s that caregivers with child care-related training performed significantly better in terms of interaction with children; provided higher levels of language stimulation to children; and tended to encourage the social development and education of children in their care. Other studies suggested that the higher the formal education of the caregiver, the higher the quality of care she was likely to provide.[9] It seemed only logical to conclude that the more trained caregivers there were, the higher the quality of child care would be overall. Since training programs are the most obvious way to increase the number of trained caregivers, the objective of enhancing the quality of child care in family day care could be secured by the mass participation of caregivers in such programs.

Yet until recently, no one had seriously examined whether training programs actually had any positive impact on the quality of child care. When these studies were finally produced, the results were more than a little surprising. A 1991 study of family day care training programs offered at two different sites in Britain was forced to conclude that "on the basis of our evidence, ... training attempts to influence child care practice in the minding situation appeared to have relatively little impact on its recipients."[10] A similar study of the Family-to-Family caregiver training program conducted by Kontos in 1994 at three different sites in the United States came to basically the same conclusion:

"In general, the results suggest that Family-to-Family training had very modest effects on family child care providers and the quality of care they provide....Process quality (focusing on the providers' interaction with children) did not improve at any site following training."[11]

These results appeared to contradict earlier studies that had identified a strong correlation between education/caregiver training and quality of child care. In fact, all the earlier studies had shown was that caregivers with relatively high levels of educational attainment or who had taken child development courses at some point in the past were now somehow "better" with children, as measured by the child quality standards being applied, than those with less formal education or who had never taken child-related training courses. They had, in other words, identified educational background of the caregiver as a key variable in explaining current behavior. However, they had never proven that a causal relationship exists between education/training and the quality of child care, much less that undesirable behavior could actually be modified through caregiver education and training programs.[12]

The more recent studies, on the other hand, sought to determine whether training could change current behavior. Though their results came as something of a surprise to a discipline that had come to believe in a strong association between training and quality of child care, they are not necessarily incompatible with the results of earlier studies once it is understood that one group of studies used educational background/learning to explain current behavior patterns, while the other sought to determine whether current or learnt behavior could actually be modified through further education/training.

The apparent inefficacy of training programs nonetheless had to be explained. The literature offers basically two types of explanations for the disappointing results of training impact studies. One group of explanations focuses on the inadequacy of training programs: training failed to improve caregiver behavior with children because the particular programs studied were inadequate to do the job. Another group identifies the source of program failure as being the caregivers themselves: training failed to change caregiver behavior because most caregivers view caregiving as an extension of their mothering role and refuse to change their views and practices about mothering. These two sets of explanations, though logically distinct, are not mutually exclusive, and often authors will use elements of both without fear of contradiction.

Inadequacy of training programs

The training programs examined in recent impact studies were all basic pre-registration or pre-accreditation caregiver courses given on a once-weekly basis over a relatively short period of time in a classroom setting.[13] In both the British and American cases, the programs were given by experienced and qualified trainers. However, they may have been too short, too superficial and too brief to produce change.[14] It should be remembered that caregivers in the earlier studies that had identified an association between education/training and quality of child care typically had college-level degrees and diplomas. Moreover, certain studies[15] suggest that classroom sessions and workshops, though they can impart knowledge, are not "a potent mechanism for behavioral change."[16]

Entrenched attitudes about mothering

No aspect of caregiving is more vilified in the literature than the notion of mothering. The dominant paradigm in academic circles asserts that women assume the role of mothers not because of biological imperative or natural instinct but because of the way they are socialized. Yet, whenever caregivers are asked what qualifies them to be caregivers, the vast majority respond that caregiving is merely an extension of their mothering skills.[17] Authors like Ferri consider this a major impediment to effective training programs. She writes:

> It might be argued that more focused, in-depth training initiatives would be more likely to produce change. Yet there are cogent reasons for skepticism, at least with regard to the subject of child care. The tendency for childminders to equate their caring role with mothering meant that their own parenting practice became the dominant influence on their approach to minded children. Since their beliefs and behaviour are likely to be long-established and deeply-rooted, this situation presents a major problem for those who seek to change child care practice through the medium of childminder training.... Until the contradictions inherent in this view are recognized, and the provision of day care dissociated from parenting, it is difficult to see how training can create the perspectives needed for a new approach to child care.[18]

Training and the Professionalization of Caregiving

The second major rationale for caregiver programs is that such programs would enhance the professional status of caregiving and the image, including the self-image, of child care providers. Though there are references to "professionalism" in the literature as early as the early 1980s, this argument is in fact fairly new, and seems to have been inspired by the need to construct and flesh-out the dialectical anti-thesis to what Kyle has labeled "mothering" discourse.[19]

In 1987, two Canadian researchers, Pence and Goelman, published the results of their study of child care quality in licensed and unlicensed family day care homes in Victoria, British Columbia.[20] They identified "professionalism" of the caregiver as a key factor affecting the quality of child care. Their concept of professionalism embraced a number of caregiver characteristics, including previous training, but was centered on the caregiver having a long-term commitment to the occupation. In a follow-up study of Vancouver family day care homes conducted in 1990, they summarize the characteristics of a "professional" caregiver as follows:

Higher quality caregivers see themselves and their work from a more "professional" perspective: they are more likely to have undertaken specific educational training, they are more likely to be licensed, they are more likely to belong to an FDC association, they will continue providing care for a longer period of time, they gather information on their children in care more systematically, and they speak with parents about those parents' children more often.

"Professionalism," as that term is employed by Pence and Goelman, designates a set of caregiver characteristics, which are strongly correlated with high quality child care in their view, and which the authors clearly associate with a professional "attitude" or "perspective" on the caregiver's part, without ever implying, however, that these characteristics derived from specialized knowledge or unique skills.

Contemporary discussions of professionalism often cite Pence & Goelman to support claims that professionalization of caregiving is necessary to ensure high quality care, but we should not assume that the term is being used in the same way or that it means the same thing as it did to these authors. Professionalism as that term is used today implies, according to Kontos et al., at least three things:

- reliance on a knowledge base not normally possessed by others;
- standards to entry into the profession; and
- training capable of conferring authority and status.[22]

Applied to family day care, the key condition for professionalization is *the development of a knowledge base or skill level not normally possessed by others*. The other requirements logically follow from the first. This implies, however, that the skills and qualifications required for child care work must be more than "paid mothering, a job for which any woman is qualified by virtue of her gender,"[23] and that caregiving take on the characteristics of a specialized occupation. Normally, the special knowledge base that people have in mind is training in early childhood education, and the skills, those of a teacher.

Professionalization as it is commonly used in the literature today refers to the process of transforming the skills base of caregiving from simply "mothering" to those more commonly associated with "teaching."[24]

If family day care providers understand that mothering and teaching are complementary rather than mutually exclusive, they may be more likely to understand that an educational focus is not a devaluation of mothering (Gramley, 1990) and that training is a worthwhile endeavor.[25]

Naturally, such a concept of professionalization has regulatory implications and would be impossible to implement without training programs.

Measuring the Quality of Family Day Care

The way the literature defines and measures "quality" is critical to understanding academic perspectives on the training of child care providers. Generally speaking, quality is defined and measured using the concepts and theoretical constructs of experts in early childhood education.[26] Early childhood education is a sub-field of the teaching profession specializing in the education of children at the pre-school level. We should not be surprised to find that the literature has a strong tendency to favor policies and programs that strengthen the educational function of family day care.

It has become standard to measure the quality of child care in family day care at two distinct levels:

- *the personal relationship of the caregiver to the child*: This is intended to measure the rapport that the caregiver has with the child. Is she sensitive to the child's needs? Does she communicate with the child? Is she warm and loving or cold and distant, etc.?
- *the activities and environment provided to children in care*: Often referred to as "global quality," this is intended to measure the extent to which the activities, environment and daily routines of the family day care home conform to what are considered good practices from the point of view of early childhood education.

There does not appear to be any standard way to measure the personal relationship of the caregiver to children in care. Various studies have adopted various techniques. In one of her studies, Kontos uses the *Adult Involvement Scale*,[27] which involves measuring the proximity of the child to the caregiver at pre-determined time intervals, to quantify the personal rapport of caregiver to child,[28] but this scale is far from universally accepted. In their Vancouver study, Pence and Goelman used the *Home Observation for Measurement of the Environment* scale (HOME scale, for short) developed by Caldwell and Bradley (1979), which measures caregiver/child interactions at eight distinct levels, for the same purpose. Other studies have improvised scales of their own.[29]

Measurement of the day care environment has, in contrast, become fairly standardized. Most studies examined in this review used either the *Day Care Home Environment Rating Scale* (DCHERS) developed by Harms, Clifford and Padan-Belkin in 1983, or the *Family Day Care Rating Scale* (FDCRS), which is simply a DCHERS scale modified for the home day care environment.[30] These scales are themselves adaptations of an earlier *Early Childhood Environment Rating Scale* (ECERS) developed by Harms and Clifford in 1980. The FDCRS is now the most commonly used measure of "global quality." It is a 33 item scale measuring program dimensions such as the personal care routine for children; creative activities; language/reasoning activities; space, furnishings and equipment; social development; and the way in which the needs of adults (caregivers and parents) are met.

Those who write and publish in the field of family day care are without question concerned above all with the quality of child care provided by family day care. How family day care homes are rated on the two dimensions of caregiver/child relationships and of the day care environment are key to shaping their views on family day care. Though this is not the place to take a critical look at the scales used to evaluate child care quality, they are obviously premised on the normative assumption that child care ideally should be a place where children not only are cared for but also are developmentally stimulated and educated.

In addition to evaluating the quality of child care, some, though by no means all, studies have sought to measure the quality of other aspects of family day care. Two of these aspects are worth mentioning: business practices of the day care provider, and organization of the day care home. Business practices are usually measured by examining how the caregiver handles such matters as income tax. Organization of the day care home is more difficult to measure; the concept of "intentionality" has recently been put forward as possible standard by which family day care homes could be evaluated on this dimension. Intentionality refers to the propensity of the caregiver to want to work on a long term basis in child care and to plan her child care routines and activities.[31]

The academic studies reviewed in this paper were all conducted by experts in early childhood education and consequently all use the definitions and measures of quality developed in that

field. It should be noted however that providers tend to define quality care much differently than do academics.[32] As described by Taylor (1995):

Providers reported patience and love of children to be the two main ingredients of quality care. Training and professionalism were not considered important to the children's welfare. Providers often feel that parenting and raising their own children are sufficient qualifications for providing family child care. Yet there is very little parenting information available. Parenting education is mostly informal and involves networking with other parents.[33]

Similarly, Galinsky[34] found that parents also defined quality child care differently than experts in early childhood education. To most parents, a high quality child care home means: a) their child is, above all, in safe keeping; b) they find it easy to communicate with the caregiver; c) a clean environment; and d) the caregiver gives warmth and attention to the child. For neither parents nor caregivers is quality defined above all in terms of learning and developmental opportunities.

Evaluations of the Quality of Family Day Care

There have been at least three types of studies of family day care arrangements. A first group of studies has compared quality of child care in family day care to the quality of child care in other child-rearing arrangements.[35] On the whole, these studies show that child care in family day care homes is no worse than in any of the other environments considered: parental home care, licensed versus unlicensed care, or family day care versus centre-based care. It is important to understand, however, that this does not necessarily mean that child care quality is universally high in all environments. These studies merely suggest that, on measures of child quality, there is little to differentiate family day care arrangements from other childcaring milieus. Since many of these studies were carried out prior to 1980, they did not measure child care quality on the yardsticks now being used.

The comparative quality of family day care environments is nonetheless still subject to debate in the professional literature. Some studies, such as the National Day Care Home Study[36] carried out in Los Angeles, San Antonio and Philadelphia, rank the unregulated sector lower on the scale of cognitive and expressive activities than either regulated day care homes or the sponsored home sector. Moreover, it found that where the caregiver looked after her own children as well as others, which is apparently more common in unregulated family day care, children were given fewer opportunities for structured play activity.[37] Numerous other studies have documented a correlation between the educational attainment of day care providers or previous training in child-related disciplines with high quality child care, and, since such "qualified" personnel are more likely to be found in centre-based and regulated day care homes, the logical assumption is that quality of child care must be inferior in unregulated day care homes than in other childcaring arrangements.

In the final analysis, the literature does not allow us to reach any firm conclusion on child care quality in family day care as compared to other childcaring situations. The standard measures of child care quality used by researchers in the field tend to equate quality with educational and developmental activities and opportunities. Day care settings where caregivers have formal education in child development and that emphasize academic preparation tend to score high on these scales, while those where the caregiver has no academic training in child development and where she acts as a substitute mother rather than teacher tend to fare poorly. Yet, there is no guarantee that these scales capture what is truly important to the child nor the essence of what childcaring is all about from parents' and caregivers' perspectives. Nor have any longitudinal studies of family day care ever been done to determine the effects that different types of child care environments have on the later development of the child.

A second set of studies have focused on the factors which contribute to the quality of child care. Though most of this research has been done on centre-based child care, the results are essentially the same as those of the few studies that have been completed specifically on home day care. Overall, the picture of a high quality family day care home that these studies present is a home where:

- the caregiver has formal education or training in early childhood education or child development;
- the caregiver is committed to providing child care as a career and over the longer-term;
- the caregiver is licensed and actively participates in caregiver groups and associations; and
- the caregiver looks only after other people's children, not her own, and gathers information on children in care in a systematic way.

As previous noted, the strong correlation between higher levels of educational attainment, and particularly previous training in child development, and high quality child care provides the major empirical evidence of the utility, if not the necessity, of training family day care providers. Though studies are not conclusive as to which is more important in this regard, high levels of formal education or an educational background specifically in child development,[38] it is not entirely surprising, given the measures of child care quality being used, that more highly educated caregivers should fare better on these scales than those without a college education. Together, these attributes of a high child care quality day care home are very close to what Pence and Goelman have labeled "professionalism" in family day care.

It is very important to note that generalizations made in the literature on the factors that make for high quality day care in a family day care setting are founded on very small sample sizes. For example, in their Vancouver family day care study, Pence and Goelman relied on observations and interviews of only 46 caregivers, and a sample of this size is rather typical.[39] Moreover, owing to the difficulty of reaching caregivers in the unregulated sector, licensed or regulated caregivers tend to be over-represented in the surveys.

Finally, a third set of studies have sought to determine the impact that caregiver training has on child care quality in family day care. While very few studies of this kind have been produced, they are among the most important for purposes of this review. We had occasion to summarize the results of these studies as regards child care quality earlier in this paper. Training had no observable or statistically significant impact on the quality of child care offered by the caregiver, based on the quality measures used, and because child care quality remains the major research preoccupation, these results struck the academic community as both perplexing and troubling. However, the Kontos study found that even if care provider/child relationships (process quality) had not improved as a result of training and even if there had been next to no improvement in global quality indicators, training had nonetheless produced significant improvements in two other aspects of family day care:

- business practices: child care providers had benefited from the specialized knowledge, particularly of the tax system, that the course had provided and were applying this new information to their business.
- intentionality: the study measured a significant increase in the number of providers who were planning their activities after having taken the course.[40]

This suggests that training is most effective in changing the behavior patterns of caregivers when it provides practical information of direct benefit and utility to the caregiver in the conduct of her business and occupation.

However, once again, we must caution about rushing to conclusions based on the modest number of studies that have been made to date. These studies generalize from limited samples; they examined only introductory courses for caregivers moving into the regulated sector; and they did not compare results with a control group of caregivers who had not taken the course. Much more research would have to be done before we could truly ascertain whether training programs "work" in this sector.

Design and Delivery Issues

The family day care sector presents some rather unique and particularly difficult problems for the design and delivery of training programs. The sector is characterized by large numbers of women working independently from their homes, largely in isolation from one another; barriers to entry are minimal and training courses are not an entry requirement (although they may sometimes be required if caregivers wish to be accredited or enter the regulated sector); turn-over rates are very high and a considerable proportion of caregivers consider family day care to be only a temporary occupation; remuneration tends to be low with the result that caregivers generally cannot afford costly training; the demands of running a day care home and of taking care of their own family as well mean that many caregivers have little time to devote to classroom instruction or prolonged course work. Moreover, there are relatively few

training programs available to caregivers, and most that do exist are tied to the regulated sector. They were designed for caregivers who wish to work in the regulated sector, and therefore are considered out-of-reach for the large number of caregivers who do not want to work for an agency or under license.

The following are among the key issues that must be addressed in the design and delivery of training programs to caregivers:

Curricula

The curriculum that would be recommended by experts in childhood education does not necessarily correspond to the needs of caregivers. While studies show that a high proportion of family day care providers feel that they could benefit from early childhood education programs, few believe they have the time to delve into this subject.[41] Indications are that caregivers would be more interested in parenting skill programs and other programs that address immediate problems in running a family day care home (income tax and accounting, networking, communication with parents, etc.).[42] Though some maintain that the curricula of caregiver training programs has become pretty standardized,[43] there is in fact considerable room for innovation in program content.

Motivation/Incentive

The literature offers mixed assessments of the willingness of caregivers to take training. Several studies indicate that the majority of caregivers are not interested in training.[44] Other studies suggest that the principal cause of low caregiver participation is not resistance to training but inaccessibility, lack of time and fear of failure in a classroom environment.[45] Whatever the case, training will not appeal to all caregivers and, if left strictly to self-motivation, only a minority will participate in training programs. The two most evident and most frequently cited options to increase caregiver participation are to compel them to take training (regulation), and/or to offer them the possibility of professional recognition following training (accreditation). Yet, experience shows that regulatory requirements of this kind are difficult to enforce, while accreditation and the possibility of entry into the regulated sector, though not entirely ineffective, would have little effect on the many caregivers who wish to remain in the unregulated sector. Linking training to the regulated sector may in fact act as a disincentive to caregivers in the informal sector.[46]

Clientele

Though the literature tends to treat caregivers in a generic fashion, as if they were all the same, caregivers are in fact a pretty diverse group. They do not all share the same characteristics, nor do they all have the same needs in terms of training. Even childhood educator scales, like the FDCRS, show a considerable difference in the quality of care offered by different family day care providers. Presumably, the providers most in need of training are those offering "poor" quality care, while providers in many of the more high quality child care homes will already have taken

training or will have a background in early childhood education. In one of the larger studies ever conducted of family day care arrangements (sample size of 900), Wattenberg categorized family day care providers into four groups: "traditional" providers, who consider training fundamentally unimportant; "modernized" providers, who are career oriented and interested in professional development; "novice" providers who are just entering the occupation and who are as still uncertain about their future in and the depth of their commitment to the field; and "transitional" providers who view caregiving as a short-term expedient, but many of whom end up staying in the field for a long time. Other classifications are possible. The point is, however, that we should not expect the training needs of a novice provider to be the same as those of a provider with many years experience in the field; nor should we expect "modernized" providers to be content with limited and short term training programs, though these might be the only ones that caregivers who do not expect to make a career of caregiving would accept. It is important to define the caregiver clientele the training program is intended to reach.

Medium/Format

Though caregiver training programs are not yet available in all communities, a surprisingly large number have been developed, mainly in response to local initiative. They typically use the medium of a small group meeting, headed by a trainer/instructor, combined with one or two home visits by the trainer/instructor.[47] Meetings are normally held in a community centre or other public building and instruction is given in a "classroom" format, complete with manuals and assignments. Many courses now incorporate films and videos in their curriculum. Indications are that one-on-one tutoring or coaching in the home and even home study courses are extremely rare.[48]

Yet, as we have seen, research shows that classroom formats, though they can impart knowledge, are not effective in terms of changing caregiver behavior, assuming that is the goal. Moreover, many caregivers find that they do not have the time to attend meetings and are intimidated by standard academic teaching methods. To get around some of these problems, some research suggests that training programs would be more effective if a) they were given by a caregiver association; b) in a common though not necessarily public place; and c) included a "mentor", a respected and experienced caregiver, to provide assistance and support to the caregivers taking the course.[49] Other alternatives, such as community television, do not appear to have been tried to any great extent. This is another area where there is considerable room for innovation.

Frequency and Duration

The frequency of meetings and duration of the course naturally depend on the nature and content of the course. Community college courses, for example, may last from four to six months or more, and involve from two to three hours of class time per week for the duration of the course. Typically, agency sponsored, regulatory and accreditation training courses involve

four to six group sessions, lasting from 90 minutes to three hours, scheduled once or twice a month.[50] Less intensive courses place less demands on a caregiver's time and are more likely to attract students, but, as the Ferri and Kontos studies show, are less likely to have any impact on child care quality.

Cost/Funding

As a group, family day care providers are classed in the ranks of the low to modest income earners. Cost to the caregiver of taking training must be kept low. Thus, programs must normally be funded from other sources, either through public subsidy or private donation. Funding constraints may place limits on the type, size and scope of the training program that can be developed.

Conclusions

There is little question that the literature strongly supports the development of training programs for caregivers in family day care. *Training programs are viewed as essential to improve the quality of child care in home day care settings and are key to transforming family day care into a profession.*

In this review, we have taken a somewhat more critical look at the claim that training programs are essential to improve the quality of family day care. We found:

- that the strong correlation between training and the quality of child care found in the literature derives essentially from studying the *characteristics* of caregivers who score high on measures of child care quality: caregivers with past training in child care and/or high levels of educational attainment consistently score better than those with less formal education;
- that most measures of child care quality were developed by experts in early childhood education and implicitly assume that the caregiver must provide an environment and follow routines that give a child a proper intellectual, physical and social education; and
- that relying solely on the results of the academic research to date, *there is little evidence that training programs in fact improve the quality of child care offered by family day care providers*; this does not mean that training courses are entirely ineffective — though they may do little to change their child care practices, caregivers often are quick to incorporate other things they have learnt in the course, in particular business methods and organizational techniques, to their day care operation.

The strong support for training programs that one finds in the literature is founded on a set of normative premises about what the day care environment should offer in terms of child

development, yet there is little empirical evidence that training programs are at all effective in transforming family day care in the directions being promoted in the literature.

Does this mean that we should abandon caregiver training programs? It is at this point that we must appreciate that the literature does not capture the views of all stakeholders. The literature sometimes gives voice to a certain frustration, for instance, with what are perceived as the misguided and intransigent attitudes of caregivers.

This tension between expert opinion and caregiver perceptions is not merely the result of superficial misunderstandings. It is indicative of a fundamental clash between an academic and professional community that wants to change family day care from what it is to a professional, more regulated occupation concerned with educating pre-school children, and the concerns, interest and realities of caregivers and their parent-clients who tend to define caregiving as an extension of "mothering" functions and who do not necessarily welcome what is often perceived as the intrusive and unnecessary regulation and scrutiny of their private affairs. Because the literature, for the most part, is produced by experts, it gives the impression that training programs must be designed for the purposes they intend. Yet training can serve other purposes as well.

There are indications that interest is growing in developing a more inclusive and expansive framework for the design and delivery of training programs in home day care. As legitimate as the objectives of the professional community may be, it is realizing that training can also serve other objectives and that training programs are unlikely to succeed unless they respond to the needs, not only of childhood education, but of caregivers and parents as well.

One of the things that strikes us the most in reviewing the literature, however, is how often caregivers are treated as if they were all the same, and how common it is to treat family day care as a monolithic industry. Family day care is a very large and very diverse area of economic activity. The literature would benefit from taking a more practical view of the economic realities facing parents and caregivers. There is probably a market for a variety of different types of family day care services, ranging from a full pre-school educational program to the more common substitute mothering role that many caregivers now provide. Training should be seen not so much as a means to change the behavior of caregivers or to proscribe professional standards for the industry but as vehicle to enable caregivers to deal with the challenges of their occupation and to respond to changing market demand for their services.

Endnotes

1. Pence, Alan & Hillel Goelman, "The Relationship of Regulation, Training and Motivation to Quality of Care in Family Day Care." *Child & Youth Care Forum*, 20(2), April 1991, p. 83-84
2. Kamerman & Hayes, 1982
3. Kontos, 1992; Galinsky, Howes, & Kontos, 1995
4. Emlen, Donoghue & LaForge, 1971; Emlen, Donoghue & Clarkson, 1972; Emlen, 1973
5. Willner, 1969; New York Infant Day Care Study, 1979; Johnson & Dineen, 1981
6. Fosburg, 1981; Ruopp et al., 1979; Arnett, 1987; Berk, 1985; Howes, 1983; Stuart & Pepper, 1988; Whitebrook et al., 1990
7. Phillips & Howes, 1987, p. 7
8. Kontos, 1992
9. Clarke-Stewart & Gruber, 1984; Berk, 1985; Whitebrook et al., 1990
10. Ferri, 1992, p. 183
11. Kontos, Howes and Galinsky, 1996, pp. 441-442
12. As most studies in this field, the earlier studies associating education and training with the quality of child care relied on statistical analysis of survey data as their basic methodology. Statistical analysis can never be used to establish causality between variables; the most it can do is test the strength of correlations between variables and the significance of variations between them. Only theory can provide explanations of the causal relationships between variables, and the test of theory is, generally speaking, its predictive value, not statistical analysis.
13. In the British study, Ferri examined pre-registration courses that had been set up by two different local authorities (Bracknell and Waltham Forest). Course content was similar though not identical and covered subjects such as child development, relations with parents, health and safety and business practices. The Bracknell course involved one-weekly, 2 hour evening sessions for six consecutive weeks. The Waltham Forest course consisted of five once-weekly, 2 hour morning sessions. In the American study, Kontos et al. examined the operation of the Family-to-Family caregiver training program, a pre-accreditation program offered under the auspices of Child Care Aware, a privately-funded national project operating in 40 communities in the United States. The study was carried out at three sites: San Fernando Valley, California, Dallas, Texas, and Charlotte, North Carolina. Though curricula varied slightly from site to site, the topics covered included business practices, local regulations, health, safety and nutrition, child development and age-appropriate activities, environments to promote learning, guidance and discipline, special needs children, parent-provider relationships, professional development and community resources, diversity issues and personal and family development. The program extended over several weeks, generally on a once-weekly basis, and totaled from 15 to 25 hours of class time, depending on locality. Unlike the British programs, it also involved home visits. (See Ferri, 1992, Chapter 4; Kontos et al., 1996, pp.430-432.)
14. Ferri, 1992
15. Kontos & File, 1993; Wesley, 1994
16. Kontos et al., 1996, p. 443
17. Kyle, 1997; Kontos et al., 1992
18. Ferri, 1992, pp.183-184
19. Kyle, 1997, p. 9
20. Pence & Goelman, 1987
21. Ibid, 1991, p. 97
22. Kontos et al., 1992, p. 192
23. Ibid, p. 192
24. Ibid
25. Ibid, p. 204
26. The vast majority of the literature on family day care is written by specialists in early childhood education, pyschologists and sociologists. Even sociologist such as Ferri, however, use concepts of quality developed by experts in early childhood education.
27. Howes & Stewart, 1987
28. Kontos et al., 1996
29. For example, Fern, 1992
30. Harms & Clifford, 1989
31. Kontos et al., 1996
32. Eheart & Leavitt, 1986

33. Taylor, 1995, pp. 20-21
34. Galinsky et al., 1994
35. Emlen et al., 1971; Vartulli, 1989; Howes, 1983
36. Forsburg, 1981
37. Pence & Goelman, 1991
38. Doherty, 1990
39. Pence & Goelman, 1991
40. Kontos et al., 1996
41. Debord et al., 1990
42. Taylor, 1995; Debord et al., 1990; Modigliani, 1991
43. Kontos et al., 1992
44. Eheart & Leavitt, 1986; Peters, 1972; Wattenberg, 1977
45. Cohen & Modigliani, 1990
46. Taylor, 1995
47. Radin, 1970; Jones & Meisels, 1987; Kontos, 1988
48. Kontos et al., 1992
49. Taylor, 1995
50. Kontos et al., 1992

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Ontario Home Child Care: Providers' Reports of Training and Educational Experiences

by Irene Kyle

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Abstract

The purpose of this paper is to summarize home child care providers' comments about their interest in and experience of taking part in a variety of formal and informal training and educational opportunities. This analysis is based on information collected as part of a larger study of how a cross-section of 15 agency-supervised and 15 independent home child care providers working in large urban and smaller Southern Ontario communities make sense of their work of caring for other people's children. The providers, from diverse cultural backgrounds, were recruited through family day care agencies, provider networks, resource centres and a caregiver registry, as well as from newspaper and supermarket ads, and by word of mouth from other providers.

The paper includes information about providers' prior education and prior work experience outside the home; providers' attitudes towards further education and training; their experience of taking part in a variety of training and educational programs; their reported interests and educational needs; as well as some of the barriers they experience in meeting them. The paper concludes with a summary of suggestions for the development of education and training programs based on provider's comments.

Research Stance

Because this information is taken from the context of a larger study, it is important to summarize some of the basic assumptions that have influenced the research approach and that frame the discussion about provider education and training which follows.

Home child care is a unique service that must be understood on its own terms, not as a modified version of centre-based care. It is essential to recognize that child care based in a home setting is a qualitatively different work experience than work in a centre-based child care setting. Home child care, carried out in the context of providers' homes, is a complex activity requiring providers to constantly juggle the responsibilities of caring for their own family and other people's children. Their carework involves all the activities and responsibilities associated not only with nurturing young children, but also with acquiring an understanding of basic business requirements (e.g., contracting, fee collection, small business income tax); becoming skilled at negotiation and communication with parents; and competent management of nutrition (food purchase and preparation), cleaning, self-care and personal stress. Providers' carework involves extensive contact with parents, not only because of the need to share information about the children they care for, but also because they often act as a resource and support for parents in a variety of other areas.

In Powell and Bollin's 1992 review of U.S. and Canadian research on parent-provider relationships in family day care, they found that "parent-provider ties are stronger in family day care than in centre care,"[1] and, at least from parent reports, "to be of a more personal and enduring nature."[2] If the arrangement works out satisfactorily, parent-day care child-provider relationships often develop into lasting friendships, which can be a source of mutual support to all concerned; at the same time, these relationships move providers well beyond the traditional expectations of professional caregivers in other settings.[3] As a consequence, there is a need to examine the appropriateness and degree of transferability of training concepts and practicum experiences developed for centre-based care to home child care. Curricula and practicum experiences should be developed to address the specific and unique characteristics of working in a home-based setting.

Home child care needs to be understood holistically, in the context of the provider's family and community setting. If home carework is to be understood, it is important to adopt a holistic or ecological approach,[4] which recognizes that the quality of care provided to young children is not only dependent on the skills, motivation and well-being of a particular caregiver, but also on the home and community setting in which she works. This means broadening the traditional early childhood emphasis on children's needs and development to include a concern for the caregiver's needs as a worker, her contacts with other adults, and the community resources and supports to which she has access. In the larger study, providers' descriptions of their work highlighted the complex nature of their inter-relationships with children in care and their parents, their own children and other family members (relatives), as well as with other providers, and staff from agencies and community support programs such as resource centres, play groups and provider networks.

Providers' accounts also clearly indicate how their carework is affected by their geographic location (e.g., rural, urban; sense of neighbourhood) and the nature of the physical resources

(e.g., housing, parks, safe playgrounds) and social resources (e.g., home child care agencies, caregiver registries, toy libraries, play groups) available in their neighbourhoods. If this holistic or ecological perspective is not taken into account, essential elements of the providers' lives and home settings may be overlooked and misunderstood.

Home-based carework is legitimate, socially productive work which frees other workers to participate in the work force. It is fundamentally important to recognize that caregiving in home-based settings is *real work*, not *just* taking in a few more kids. Because carework occurs in a home setting, it must not be taken for granted. Carework is "gainful," socially productive employment. Provider training is training for women's employment. Through their carework, providers not only contribute to the financial support of their own families, they also enable working parents to participate in the workforce and thereby contribute directly and indirectly to the economy.

If carework is accepted as legitimate work, then providers' needs/rights as workers must also be addressed. This involves clarification of their employment status (are they employees or independent workers?) and provision for basic benefits such as unemployment insurance, pensions, sick leave and so forth. The current lack of agreement about providers' status (e.g., in employment, labour and tax legislation) makes it difficult for any group that sets out to train/educate providers to be clear about what the focus and content of the learning material should be. However, simply ignoring or overlooking these issues, as is often the case in present approaches, only postpones their resolution, and further reinforces the exploitation of providers.

Home child care providers' knowledge, experience and opinions must be respected. The bulk of prior research, and much public policy related to home child care has tended to focus predominantly on children's welfare, and on how to make this form of care a safe, high quality public service for young children. Providers' needs and issues as workers in their own right have largely been unexplored and their carework tends to be taken for granted. In her writing about English childminders, Owen has commented on this problem:

Anyone reading the literature on childminding until very recently comes away with an overwhelming impression of objectification. Childminders and the work they do are talked about, often in highly critical terms by journalists, academics and politicians just as if they are not there, or do not have the ability to understand the discussion.[5]

In Ontario, for example, public policy places responsibility for ensuring quality care, not with the worker directly providing care (i.e., the person who has the immediate responsibility and power to make things happen in the care setting), but with a public agency that is separate from but nevertheless held accountable for the carework that takes place. In this construction, home child care providers are treated as "subjects" to be monitored and supervised, rather than as autonomous workers who are held directly responsible for the care they provide.

The child care professional (home visitor) is seen as the expert, the supervised provider as more of a "client," than a co-worker and colleague. Independent providers are often considered to have even less competence. Providers also tend to be treated as though they belonged in a single careworker category, so that there are few provisions in place that recognize the skills and knowledge individual providers may bring to their work through their prior education and training, their current participation in community support programs, or their actual caregiving experiences.

In contrast, in the larger study, home child care providers' accounts of what constitutes a good caregiver, and the characteristics they identified as being important in doing their work, indicated that many providers bring a clear sense of personal responsibility and an "ethics of care" to their understanding of carework that are consistent with, and complement more academic and professional notions of quality. This suggests the need for a fundamental shift in the way providers are viewed, from that of "client" or "subject" to that of colleague and collaborator, and that training/education programs adopt an approach that validates and builds on the experiential knowledge providers bring to their studies.

Methodology

Recruitment and interviewing

A cross-section of agency-supervised and independent home child care providers in southern Ontario[6] were recruited and interviewed over the course of a year and a half (January 1994 to August 1995). Fifteen of the providers were supervised by seven home child care agencies; 15 were independent. Providers were recruited through family day care agencies, provider networks, resource centres, and a caregiver registry, as well as from newspaper and supermarket ads, and by word of mouth from other providers, in an effort to obtain as broad a cross-section of providers as possible.

Intensive semi-structured interviews, averaging approximately 2 to 3 hours in length, were conducted in providers' homes. Reinharz recommends the use of semi-structured interviews when "the researcher plans to ask questions about a given topic, but allows the data-gathering conversation itself to determine how the information is exchanged"[7] and when it is important to ensure "the active involvement of the respondents in the construction of data about their lives."[8] I chose this methodology because of my interest in focusing on providers' own understanding and experiences of doing carework, and my concern about not wanting to continue in the traditional "expert" stance of making a priori judgements about what providers' perceptions and experiences might be. This stance also seems consistent with Bogdan and Biklen's assertion that the goal of qualitative research is: "to better understand human behaviour and experience...to grasp the processes by which people construct meaning and to describe what those meanings are."[9]

While all providers were asked basic questions about their carework, there was no set order to the questioning and each provider was encouraged to speak about her ideas and experience in her own way. In interviewing providers and analyzing their comments, my approach has been to view the providers as "expert practitioners"[10] who, because they live and work in a particular setting, are the ones who understand its organization: "their vocabulary, the taken-for-granted concepts that organize their talk, the structure of their accounts, all serve as features of the talk that express the social organization of the work."[11] All the interviews were tape-recorded and subsequently fully transcribed. Coding categories were built up directly from the data using Nud*ist software,[12] rather than fitting the responses into pre-determined categories. These categories were then analyzed to identify key themes and issues.

Description of providers

Table 1 summarizes demographic and social characteristics of the providers who were interviewed:

TABLE 1

Demographic and Social Characteristics of Providers
N = 30

Age Group	
20-29	1
30-39	15
40-45	9
over 45	5
Education**	
< High school	1
High school	11
Community college	9
University	10
Other training	4
Marital status	
Married	25
Single parent	5
Total Family Income (1993/94)	
$15,001-25,000	5
25,001-40,000	8
40,001-55,000	10
55,001-60,000	5
>$60,001	2
Gross Child Care Income (1993/94)	
<$5000	2
5,001-10,000	5
10,001-15,000	4
15,001-20,000	10
20,001-30,000	7
>$30,001	2

** Note: Some providers may fall into more than one category

Most of the providers lived in various parts of Metro Toronto; six were from nearby, smaller, more rural communities—Alton, Bolton, and Fergus. Providers' cultural backgrounds were diverse, including women of Greek, Italian, East Indian, West Indian, Spanish and Middle Eastern origins, as well as those of British and Northern European descent.

While providers reported an average total family income between $40,001 and $55,000, several of the married providers were the major income providers in their family. One provider was on social assistance.

All but one provider had children of her own. Ten providers had their own children age 6 and under; 15 providers had children aged 7-12; 16 providers had children who were over age 12. Three providers' daughters had gone on to study early childhood education.

Caregiving status

While there is a tendency for researchers and policy makers to categorize providers according to their regulatory or supervisory status, the supervised-independent dichotomization is much less straight-forward than is often assumed. So, for example in this study, an experienced provider may have had experiences with several agencies, and/or may regularly combine caring for private and agency children. At the time of the interview, 8 of the 15 agency-supervised providers reported caring for private children in addition to agency-placed children. Five of the 15 independent providers had had some prior experience of working with an agency. Although a few of these providers had stopped working with an agency because of their dissatisfaction, others were no longer connected with an agency because they had moved to an area where no agencies were in operation, or where agencies were not taking on more providers due to funding limitations.

Caregiving experience

With one exception, I chose to interview providers who had a minimum of 2 years experience offering care so that their perceptions of their work would be solidly grounded in their experience. (The caregiver who was an exception had only been working as a provider for about a year. Prior to that, she had worked for a number of years as a home visitor for two different home child care agencies.) Of the 30 providers interviewed, 7 had offered care for less than 5 years, 14 providers had 5-10 years experience, 5 had 11-15 years experience, and 4 had from 16-22 years experience.

Several providers had had experiences of working with another provider to offer "family group care" to more than five children. (While "family group care" is established as a legitimate mode of care in some U.S. and Canadian jurisdictions, it is currently not recognized in Ontario, and is technically illegal here). Prior to offering home child care, a number of the providers who had worked outside their home had been a day care parent themselves. Several

of those providers who had used family day care had kept in touch with their own child's provider, who they turned to not only for occasional support concerning their own children, but also for "how to do it" advice and support.

Number of children cared for

Counting the number of children cared for is surprisingly complex – some children are full-time, others are cared for part-time (part-day and/or part week) or on an occasional basis; some children come on the weekends, and several are cared for overnight. Despite making a conscious effort in the interviews to clarify the number and ages of children providers were caring for, in several instances, I did not feel that I necessarily had a totally accurate count. While a few providers may have been hesitant to share this information, my sense was that confusion arose because providers did not always include occasional children (e.g., school-aged children who perhaps may come for lunch or after school several days a week) in their numbers. Three providers also offered overnight care for children on a regular basis. In total, providers reported caring for 121 children, with most typically caring for 3 or 4 children. Half of the providers were caring for children with special needs or had cared for them in the past; several others were also caring for their own children or adult relatives with special needs.

Most independent providers were aware of the provincial regulations limiting the numbers and ages of children legally allowed to be cared for, and voluntarily complied with them. A few independent providers were observing the regulations in respect to the total number of children allowed, but not in relation to the approved age groupings (e.g., having more than one infant). While this is not illegal under Ontario regulation, it is not allowed for agency-supervised providers. A few providers were operating illegally, at some points in time caring for more children than permitted; several providers admitted to having done so in the past. Although providers told me about other providers illegally caring for large numbers of children, I was not able to find or interview anyone who fell into that category.

Home and community settings

Most providers lived in houses, some of which had spaces (such as a playroom or play area) specially organized and set aside for child care. In most homes there was comfortable evidence of children's presence, with toys and equipment such as high chairs and playpens on display. Five providers lived in high-rise apartments in the more dense urban areas of Metro Toronto, and two providers lived in townhouse complexes. The standard of housekeeping in providers' homes was quite variable, from neat and tidy to extremely messy, with most homes falling somewhere in between. Most providers talked about the challenge of keeping up their housework while doing carework; a few providers regularly hired "cleaning ladies." In a number of instances, parks and various community recreation centres were nearby. Many of the providers took part in local play groups, drop-ins, resource centre programs and provider

groups; a small number were quite isolated. A few providers I interviewed had been involved in setting up provider support groups and in advocating for providers; many others described being involved in a variety of informal contacts with other providers, neighbours and members of their extended family.

Limitations and qualifications

One of the limitations of qualitative research is that, given the lack of a statistically representative sample, the research results cannot be generalized to all home child care providers. The strength of the methodology, however, is that it allows for more complex, detailed and subtle understandings of the particular meaning that carework holds for the providers who were interviewed because information is gathered in a way which encourages them to define or construct their own version of their experiences. There is no way to be certain of the extent to which providers' accounts are similar to, or different from, the many other providers who were not interviewed. This is the subject for future research.

It is also not possible to know what providers left unsaid, or left out because of limitations of time, discomfort, or self-censure. For this reason, this research is not "objective" in the traditional positivist sense, nor is it intended to be. As noted earlier, the research focuses solely on provider perspectives and, therefore, does not take into account the potentially competing constructions and experiences of day care parents and children, nor of agency staff (except as they are seen through the eyes of providers), which would be required in the most fully-realized ecological approach. While providers' views are necessarily subjective (i.e., socially-constructed), they nevertheless offer many valuable insights into the workings of home child care, and provide perspectives that historically have too often been overlooked.

Because few representative studies of home child care providers have been carried out in Canada, there is no baseline against which to systematically evaluate the limitations of the present study sample. While the providers interviewed include a cross-section of providers from different age groups, cultural and ethnic groups, education and income groups, as well as agency-supervised and independent providers, the very richness and diversity of their backgrounds and experience suggest that, at least in this area of Ontario, notions of what characterizes a "typical" home child care provider may be far too narrow and stereotyped. The commonly-held assumption that supervised providers offer a higher quality care than independent providers does not appear to hold true for this sample and is too simplistic; variations within and across both provider groups were much more complex. Tuominen interestingly, has also reported considerable diversity in the home-based child care workers she interviewed, noting they: "...are not an homogenous group." and "...differ in race/ethnicity, cultural affiliation, formal education, employment history and the local markets in which they can sell their labour."[13]

The decision to interview providers with a minimum of 2 years experience may have contributed to some biases in the sample by eliminating providers who had worked a shorter period of time,

and who, therefore, may have been less committed and more tentative about being caregivers. Some studies of home child care providers have indicated, for example, that there can be fairly high turnover rates. A 1988 survey of Ontario agency providers found an average provider turnover rate of 40% in the year prior to the survey,[14] and that only about 40% of providers had been with their current agency for over 2 years.[15] Because the Norpark survey was limited to studying agency-supervised providers, however, it is difficult to know how many of those providers who had ceased working with agencies continued to do carework independently on their own.

I was also surprised to discover that so many providers (8) had training in early childhood education, for in my recruiting efforts I had focused largely on whether or not caregivers were independent or agency-supervised. On reflection, given the known high turnover rates of child care centre staff, the closing of some centres in the Metro Toronto area due to funding cutbacks, as well as the high cost if a centre-based educator has more than one child of her own who requires care while she works, it is not so surprising that some of these early childhood educators decided to become home child care providers.

In citing excerpts from provider interviews, I have reported their comments largely verbatim, with minor editing out of the extraneous, "you knows" and "uhmms" that naturally occur in everyday conversation. I have also occasionally added a few words as indicated by [ ], in an effort to make the meaning or context of the comment clear to the reader. It should be kept in mind that the first language of some of the providers I interviewed was not English, so that sometimes their comments may seem more awkward and less fluent; their ideas, however, are generally not.

On rare occasions I have changed references in the text which might break with confidentiality and indirectly lead to a provider being identified. In these instances, I have worked to substitute alternative references which preserve the original intent. My goal has been to create a multi-voiced text[16] in which a range of providers' voices are heard alongside that of the researcher's comments and interpretations. Providers' accounts are amazingly intricate, complex and multi-layered — not easily captured in any linear account. In the course of doing this research I have time and again been struck by the wisdom and articulateness of many of the providers I interviewed; I hope that what follows will in some small measure convey that sense.

Findings

Formal training in early childhood education or related human services

Providers' reports of their caregiving experiences and training were quite varied. Six providers had completed two year programs in early childhood education at the community college level, studying at Centennial, George Brown, Seneca and Sheridan colleges. One provider had taken a shorter ECE course at Canadian Mothercraft Society, while another reported studying in Halifax at the St. Joseph's Children's Centre. After completing her ECE diploma, another provider had taken

the day care management course at George Brown College. Of these 8 providers, 3 had returned to study early childhood education in the evenings, after they had some experience working as home child care providers.

Among the community colleges mentioned, only Sheridan College was reported by providers as offering specific courses related to family day care. In a few instances providers attending other colleges commented that they were able to choose family day care topics in working on course assignments or projects. Overall, there was a sense that discussions about various aspects of family day care were generally absent from the curriculum.

Other providers in the study reported having training or experience in related human service areas. A few providers had worked as nannies (they did not have their NNEB), or as foster parents; one provider had been trained as a youth worker, and another, as a primary school teacher. One provider had taken nurse's aide training, and several others had some training in nutrition. Twelve providers had high school training or less.

Prior work experience outside the home

About half of the providers interviewed had had some paid work experience outside the home prior to becoming a home child care provider. One provider had been trained in industrial design, several had worked as secretaries, several as cooks or caterers in food service industries, another had worked in a social agency, one was a primary school teacher and one had worked in a bank. Many providers reported that their decision to offer home child care had coincided with their desire to stay home to care for their own young children and, at the same time, to continue contributing to family finances. In a number of instances this decision coincided with the birth of a provider's second child, and came about because she felt the cost of paying for day care for two children was more than her family could afford, and/or because she was not entirely happy with her first child's day care experiences.

One provider explained:

...I was doing my E.C.E. at night...when I started home day care, I hadn't finished it yet. And you know I had to go and do placements, I found it very hard to leave my kids, but I had to go and do placements... so I felt like I was leaving them in maybe somewhat lesser care than I was going out to provide to other kids... I didn't like that, I wanted to stay at home with my own kids. And then I thought, "Well, why not? Why not set up my basement as a day care and work from home".

One of the providers trained in ECE had worked for a number of years as a home visitor for two different Metro Toronto home child care agencies; she left that work in order to stay home and raise her own children. Of the 8 providers trained in ECE, a few had worked on an occasional basis in group care centres. Some did not see working in a centre as a future goal, in part because of their strong preference for working in a home care setting.

One provider explained, for example:

...I graduated in 1982, and left the field as soon as I graduated. I didn't...go into it...[IK: So you never worked in a daycare?] After I graduated, no. After I got my diploma, that was it. I stopped. [IK: Was there a reason in particular?] I didn't like the way the day care centres were run. That was the big thing. It ate at me constantly. The way they did things, and it was...this isn't right. This isn't the way I'd run my home, so it's not the way I'd expect ...You know, it's not the way I want my child raised, so I wouldn't, I didn't feel comfortable raising other people's children in day care settings the way I wouldn't want my own child raised. [IK: So you never, you went on to do other work and then...] I went into...I went on to other fields... I went into office work at that point. And when I had my first child, there was never any question as to where she'd go when I had to go back to work. After having my first, it was...she was going into a home day care program and there was no question about it. But I was raised with my mom. My mom did home day care, so we were always raised in that setting and I was comfortable...

There was a sense in which providers who felt this way about working in group settings saw their ECE training as giving them a kind of insurance policy for the future – they could always fall back on it if things were desperate – but in the ordinary course of events they did not wish to pursue a career as a worker in a child care centre. Not all trained providers held this opinion: one of the providers with ECE training saw herself as moving to work in a family resource program in the near future and had already started discussing arrangements for her own children to be cared for by a neighbourhood provider; another provider was studying part-time to become an elementary school teacher.

Most of the providers who had studied early childhood education generally felt that it had been worthwhile and contributed to their overall understanding of children:

...I really did enjoy going to school and doing all the courses in child development, and curriculum planning, and stuff around principles of day care. All these things really sort of changed my, or not necessarily changed, but certainly directed me in the right direction as to, what, how to think of kids... Because I had a lot of experience with working with kids in camps when I was a kid, you know...nothing formal; and I really do think that it helped me a lot.

This woman went on to say that she felt the training gave her greater credibility with parents and that it also helped in developing her own sense of self competence and ideas about child care.

Another provider talked about the value of her education in a similar vein, and noted that it had helped her to become more conscious of what was happening with the children in her care, gave her ideas about how to support their development, and information about community resources that were available to her. She also gave an example of how this awareness helped her to identify, early on, a problem that one of the children was experiencing:

[IK: How do you think taking the [ECE] course has influenced how you think about home child care?] Oh greatly! ...I think it made me more aware of the developmental milestones...what to look for...not look for, what to notice. There was one little girl a couple of years ago, who was, her mother and I were talking, she said, "She won't listen to me when I'm talking to her at home, she just completely ignores me." She said, "I don't know if she's going through a stage where she's just being really rebellious, I don't know what the problem is". And I said , "yeah, I've noticed that too"... So we talked about it some more, and we both were watching her more, and started noticing her more. And I mentioned to her mom, I said, "You know, she's not doing it just to us, she's doing it to the other kids as well". And the other kids started to say, "Hey, she won't listen to us when we talk to her." And after a week or so, you know, we found that she had a 40% hearing loss, that...she was having ear infections, and it was corrected and things got straightened out because we caught it early enough.

But I'm not sure that I would have noticed it without having some of the training that I had through the ECE course, or if I would have noticed it as quickly. You know, we've been made aware of some of the things, the way children interact with one another... It's made me more aware too, of other resources that are out there and different things I can do too, when I'm talking with the children... [IK: ...it made you more conscious....] It certainly made me more conscious of a lot of things. It's helped because of planning activities and...it gave me ideas of what to do, and even more age appropriate activities when the children were younger. How to take a little more advanced one [activity] and scale it down a little bit so that we could have two age groups doing the same thing, but in different ways.

One of the frequently recognized limitations associated with home careworkers is the absence of a career ladder that allows experienced providers to advance to more senior positions and responsibilities in the child care field. However, two of the more experienced providers were in the process of expanding their own work and aspirations, drawing on their experiences of helping to organize and participate in provider groups. One agency-supervised provider had helped to start a drop-in program in a nearby elementary school several mornings a week. At the time of the interview she was being given a small remuneration by the school, which allowed her to reduce the number of children she was caring for, and to spend time developing drop-in activities. She expressed a hope that she would be able to continue to develop the drop-in program in the future.

Another provider, as a result of her networking with others, had become interested in a number of parent/caregiver support issues. She worked together with a local family resource program to obtain funding to conduct a survey documenting the need, carried out the research, and was developing a funding proposal to start a new program to address the needs that were identified. A third provider and her husband had invested in a commercial family day care franchise and she was beginning the process of switching roles from caregiver to manager and home visitor.

Carework by choice, not out of desperation

In *The Kin Trade*, an early study of family day care arrangements in Toronto, Johnson and Dineen painted a bleak picture of caregivers' reasons for offering home child care:

...Most women fall into caregiving because they feel that they have no other choice. They don't really find the work worthwhile or valuable to society. They can't wait to get out of it and find a job outside the home. They feel trapped in their caregiving jobs because they have young children of their own, or don't speak English very well, or can't find another kind of work, or have some illness or injury that keeps them at home.[17]

Most home child care providers interviewed in this study presented quite a different picture – one characterized by their conscious choice to provide care because they enjoyed their work, and a clear interest in and commitment to working with children. One provider expressed it this way, in response to my asking her what she considered the most important aspects of being a good home child care provider:

...the first thing is that you'd have to love kids, because if you were just in it for the money, then it wouldn't work and you wouldn't be happy, and it would go onto the children. So the first thing is that you'd have to love kids, that you'd really want to do this. And then to learn about it, obviously. Do it like I didn't do it, from [talking to] others, by getting reference books, because there are books out there on it. And talking to other caregivers, at least another caregiver about the experience...

When I asked providers if they saw themselves continuing to offer home child care for the next several years, most did and many made additional comments indicating that they did so by choice and not because they felt they couldn't find other work or felt they had no other options. For example, one provider commented:

...I love this job. I like it....if I go outside [the home], like I work in so many places, like I work in a factory, I work in a store. I've been able to go work outside if I have to, but I think this is something very special for me. I love kids and they love me back, and you know, it's fun with the kids.

When I asked another provider what she liked most about doing home child care she responded by comparing the satisfaction she got from being a provider with her experience of being a legal secretary. There was no contest. In her view, being a provider was clearly more gratifying:

...there's lots [of things I like]...the kids, themselves...you know there's nothing better, there's not a better way to start the day than a hug and a kiss in the morning—hello, and a hug and kiss when they go home...There's nothing that makes your day...it makes it worthwhile getting up in the mornings to see that smile on their faces when they walk in the door and you know that they

want to be here. There's nothing like it, nothing like it. I mean I worked for a lawyer for 10 years and in 10 years I never got shown the appreciation that I get in one day with my kids...

Another provider who had previously worked in a social service agency, and was now in a position to resume a professional career, talked about her growing interest in working with children and her decision to continue providing care rather than working outside the home:

Well, originally, when I started, it was just until both of my children were in Grade 1, full-time school, and then I was going to go back [to working outside her home]. That happens this year...so this would have been the time I could get out and do something else. Only I've decided I really like this, and I really want to continue it, so I'm really looking forward to staying with it for awhile...I do have my goals for later on; I would like to get back into it [former work], but right now, I'm really getting into children...

While frustrated by the lack of recognition accorded to home child care providers, another provider (who obtained her ECE diploma studying part-time while doing home child care) made it clear that she chose to provide care, not because she had no other alternatives, but rather, out of interest:

...I don't have to be home here. My son is 11 years old...he went to school four [sic] years ago, full-time. I mean, I could have been out the door anytime. I've made a choice...It's not like I can't get a real job. I haven't chosen to get a real job because this is what I like to do.

Her comments about getting a "real" job are also interesting in that they show how the provider is caught up in the general social devaluation of her carework, even as she's struggling to obtain greater respect and recognition for what she does.

Attitudes towards further education and training

While some studies have been quite disparaging about providers' attitudes towards learning and training,[18] many of the providers interviewed in this study identified the importance of having access to a variety of opportunities for training in early childhood education and child development, in working with children's parents, in business practices, and in other areas touching on their personal growth. Part of the problem with earlier research arises from the suggestion that caregivers fall into two categories; caregivers who see their work as an extension of their mothering, and those who see themselves as professionals. For example, Kontos, Machida, Griffin & Read conclude that: "the major barrier to linking training and professionalism is the belief by some caregivers that family day care is simply an extension of mothering" that suggests that "a need for training denigrates a woman's natural caregiving abilities."[19] The adoption of these two categories sets up a false dichotomy that is too simplistic and ignores the more complex and evolving thinking reflected in many caregivers' comments.

Although many caregivers in this study did make comments indicating they felt that their experience as mothers had helped them in caring for other's children, at the same time many felt that it was equally important to continue their own learning and to keep up to date with current thinking. Their interest in continuing to learn stemmed from their sense of feeling responsible for the kinds of experiences they offered to the children they were bringing up—both their own and other's children. Many providers recognized that raising children is not a simple task, and commented on their continuing need for information, reassurance, and support so that they could respond more adequately to the ever-changing challenges of their carework.

For example, one provider who at the time of the interview had almost completed her 2 year ECE diploma while continuing to do home child care, commented:

...like I said, it started off as I...just wanted to stay home with my kids and this was a chance to have extra income, but it has changed from that, you know. I've realized that I do enjoy it, and so that's made me go on to further studies to continue it...

In talking about what was important in doing home child care, another provider clearly saw the learning process as a continuing, progressive one:

...I think while you have to have some knowledge of working with children, it is also something that can be developed over the years, so I would say a certain amount [of learning is necessary] to begin with, which you could... [IK: and an interest in developing it then, maybe?) Yes, yes. Umh, a desire to develop it as you go along and get more, you know — educate yourself. Because there's always new things coming up where you need to update yourself and keep [aware]; whether it be rules and regulations, or whether it can just be what kind of flus or viruses, or diseases, or anything that could affect your doing day care, [that] has come about in the last few years. You have to keep yourself educated where that's concerned.

Another provider talked about taking several parenting courses, including being involved in a *Nobody's Perfect* group that continued to meet regularly to discuss their ideas and concerns, even though the group had finished the course. She also talked about her ongoing interest in learning about children:

[IK: It sounds like you've taken a lot of courses.] I've always been that way though. From the time I was sixteen, I was reading books on child-rearing. Because that was something of interest. I mean I was 18, not married, no kids, I was telling my sister how to raise her kids. She was not impressed, at all. [IK: So now you've got a lot of expertise...] Well, now I feel like I'm...there's still all kinds more that, that I need to learn. I mean things change all the time from one technique to the next and I want to constantly be informed of what changes there are and I mean I...these guys [her own and the day care children] are really important. They're going to grow up and be their own people and I want to be part of that, [and] make sure I'm planting all the right seeds if I can.

I asked one provider (who had worked for 12 years in home child care) if she had to do it all over again would she still choose to be a caregiver. She replied:

I'd have to say yes. All over again, maybe to a bit different degree. I think maybe I would have tried to be more educated prior to becoming a provider, you know...but I think I would still be definitely in the same career. Yeah, but I think I would like to be more educated.

She went on to explain that while she would like to learn more about child psychology, she also thinks it is important to integrate her learning with her own experience:

I would really enjoy a child psychology course...but I think I would rather have done care first, and then try it out, because you can't learn as much from a book as you can hands on. So, I think that would be interesting.

Another provider (with 19 years experience in home child care) commented on the fact that when she began offering care, there were few courses or other learning opportunities available. Over time, this has led her to become active in a local provider network, and to work with other providers in the development of workshops and other information and resources:

Maybe I've thought more about training and so on because it wasn't there. There's a lot of things that weren't there. If they had been, I think I would have done them then too. They just weren't available when I was younger and my own [children] were younger. It just wasn't there and it hasn't even been in this area very, very long.

Another provider who had been involved in helping providers in her neighbourhood to get together, talked about other providers' needs and her sense of their interest in, and willingness to learn more:

[IK: What other needs are you seeing?] Relief is a critical one...uhmm, the education. These women, they want to be educated. Those that are serious, and they make up the majority. I have phoned...I was calling people to let them know about the network, so I took some classifieds out [in the local newspaper] and I was calling these women that had ads in there. And the first three I spoke to were like, "Oh, thank God, somebody's doing something for us. We really, we need...we need help, we need help to do this important job."

While one of the providers (formerly a nanny) expressed the view that she did not have much to learn about caregiving from further training because of her prior experience working with children, at the same time, she recognized the value of having a diploma and the legitimacy it offered. Interestingly, she also expressed a strong sense that what she needed to learn about children she could get from closely observing them – an interesting echo of the child-centred focus in ECE approaches. English is not her first language, and her awkwardness with the language is evident in the following excerpt. While she did not mention it as an issue, her present lack of fluency would also make it difficult for her to participate in most formal training programs:

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[IK: Have you ever done any training, yourself?] I was thinking to do something about this... Yeah, I don't know... [IK: ...had you thought about what kind (of training) in particular?] Because, I take care [of] babies...I say, I know everything about babies, what [are] they going to train me there? What [are] they going to tell me? So that's what I think, what [are] they going to tell me? Nothing new... Sometimes I think it's important to have that diploma...It doesn't ...mean nothing. [IK: Have you read anything about caring for children, or is your experience...] My family is [my] experience... is from my background.

[IK: From your own background, yeah. You mentioned that, so...you've been around kids a lot it sounds like...] So that's why I think, why [am] I gonna go to the school, what're they going to teach me, I can teach the teacher. (She laughs.) [IK: Well you probably could, too...Have you ever found things though that you wondered about? Like you've thought, Gee, you know, I really wonder about doing that that way, or...I really wonder about this kid. I mean, have you ever had things that you didn't know what to do about... looking after kids?] Well, no. I think it's nothing...[you have] to learn from the kids. You just got to do it, and they keep teaching you what they need. So, it's something they come with, day by day. It's nothing you can teach that person to do. I think this is silly to teach it. You just start with the kids and they will teach [you] by themselves.

Reports of informal training experiences

Most providers in this study reported having taken part in a number of informal training experiences through participating in workshops, discussion groups and courses offered by agencies, family resource centres, toy libraries, caregiver registries, or organized by provider networks. The majority also reported having taken a first aid and a CPR course. Because of their interest in and experience caring for special needs children, several providers had taken workshops offered by agencies serving children with various disabilities such as Play and Learn, the Hanon Children's Centre, or family day care agencies to assist them in caring for special needs children. As noted earlier, a few providers had also participated in training in their own right as parents, taking part in Nobody's Perfect groups, or parenting groups for foster parents, or for parents with special needs children.

While home child care agencies in this part of Ontario vary somewhat in their approaches to provider orientation and training and their requirements for caregiver participation, all of the agency-supervised providers interviewed had taken part in at least some training sessions and workshops. In general, most agency-supervised providers felt that this training was helpful, especially when they were just starting out. Many also remarked on how much they learned from talking with other caregivers, and how supportive it was to share ideas with other women who were going through similar experiences. For example, one provider commented:

[IK: Do you get involved in...the activities the agency has?] The workshops every month? I try not to miss any. Actually, I think there's two that I don't go to. Like one this month doing

income tax. I don't do my income tax so it's not necessary that I go, but I try not to miss any of them. [IK: Do you find them helpful?] Yes I do, yes I do. Plus you get a lot of feedback from other providers on what they're going through. And I used to think I was alone with all these problems, right? 'til I find out that everybody else has the same problems. You're not appreciated, I think, that's a lot of it. [IK: That must be the hardest, the hardest part of the job.] Uhmm, yeah, I believe so.

Another provider expressed a similar opinion about the value of getting together with other providers, and commented on some of the topics and information that she found useful. She began by saying that the agency required caregivers to attend the workshops:

...Yes we have to go. Well, some people they didn't want to go before, but now they make it a "must." [IK: uhumm. Do you think that's a good idea?] In a way, yes, because you meet the other people there, you meet other ladies there, you can talk to them. Well of course, when we meet all of us are talking about the kids and nothing else. And of course, you hear something new, that clicks something in your mind and you say, "Ah, that's a good idea" ....because we exchange ideas, and sometimes recipes, and sometimes...it depends on the meeting and what it's about. So always you have something: [what to do] in case of an emergency, everybody [talks about] their experience; training, toilet training, and everybody has a different idea; and how comfortable people are talking; and how you approach a [difficult] subject with parents. And always it helps. Because sometimes maybe you think, "I have a problem there," and then you hear somebody else, and you think, "Oh, maybe I can try that." You know, they do help. Of course, you have to be open mind[ed], to welcome new ideas. And if you have an open mind and you welcome ideas, you make your life much easier...

Another provider commented at length on the kinds of topics she found helpful and interesting that were included in the agency workshops she attended; most were very practical, offering support to help her with the day to day activities of her carework:

[IK: Did you go through all the training?] Oh yes, yes. [IK: What things did you find helpful in what they taught you?] So many things, so many things. I went, like they have all different kinds of workshops... Like when you first start, you have to – it's compulsory to take three meetings...and they give you certificate... In that time, like they teach you what to do in emergency situation, and they teach you the first aid and all those things, but after that, they teach you all different kind[s of things], like the school-aged kids that you have, they teach you what books to choose, what activities to do. And then if you have babies, like how you have to handle them, how to feed them, how to manage them, and then sometimes they teach you all different kinds of things. So many things, so many. And whenever I go, I really enjoy [them]. It's really something nice to learn every time.

I then went on to ask her about what other things she would like to learn in the future; she talked about an agency workshop that was planned to address multi-cultural issues. This

provider, who is East Indian and a Moslem, looked forward to it not only because she felt it would increase her awareness of other cultures, but also because it helped her to think through how to talk to the children she cared for (who were of a different cultural origin) about her own culture and answer their questions about her religion. She commented:

...They have something coming up in May. They talk about all different cultures and they...research everything, like you know, Black community, or Indian community, or Greek, or Somali, they do all kinds of things and they put it all together and then they talk about it. Like what kind of religion you are in, and then what you do in your religion, and then what I do in my religion. And then it's important to know, like why I wear my scarf. And the kids will ask me why I'm wearing a scarf. They [the agency] tell me what I have to tell them. Like... [it's important for] kids learn about the different things, and not to be racist, so they all kind of...so it's very important. They teach you so many things.

Providers also like to be able to pick and choose the workshops and courses they take, and to be free to follow their own interests. One of the providers I interviewed regularly attended workshops offered through a family resource centre; in addition to regularly attending the "Caregivers' Morning Out," she would also take part in workshops that interested her:

[IK: How often during the week would you go to the centre?] On a regular basis, Tuesday morning when it's Caregivers' Morning Out...for the next 2 weeks actually, I will go back Friday morning because I've signed up for a workshop. Now I don't do that every Friday, I do it when I find there's a workshop that appeals to me. Some of them [workshops] don't. Some of them are potty-training. Well there's not a whole lot more you can do outside of what we do here. [IK: You could probably give the lesson.] At this point, it's like I don't want to go to that. If they're talking about things that maybe I was having a problem with, but I'm not now, I think I'll leave that door open for somebody who really is having a problem with that. I don't need to go just for the sake of going. I've been to a few of those. I can wait for another one. This one that's coming up is on children and values and I sort of thought, oh, I'd kind of like to hear what they have to say...and it's a 2 week one and I thought hmmm, I would like to go listen to that one. [IK: *And then they have child care while you're...] Yeah, while we're at the workshop, they handle the child care...which is great.*

Providers associated with family resource centres and provider networks talked about getting together to support each other's learning in other ways, such as sharing information through newsletters and developing other resource materials. The value of this work is not only in the learning that comes from putting this information together, but also from the contacts and informal support they offer each other. One provider explained, for example:

At our last network meeting, we decided for our own benefit, we wanted to put together a booklet of some craft ideas, some recipes, some [other] ideas. Just good things that worked for you or just maybe you thought was a good idea. There's a couple of suggestions in the

book. There's some things out of other books, things that worked really well. And we ended up, I think, with 22 pages back and front. There was 8 or 9 of us that contributed, but there was a dozen of us involved. I mean, someone would contribute an idea and someone else would say, "Well why don't you do this with it?" They won't take credit for it being their idea because someone else brought it, but a lot of them is crafts which is a big thing for providers wanting extra crafts. Just sharing ideas on what, you know, some ideas about a tears bucket [?] and how it worked, and different outings, and just all kinds of things. Different things to do with gingerbread houses. All kinds of ideas. It does not have a cover page. Two pages in here you cannot read (she laughs.) They did not come out very well, we didn't even realize it, we were doing it so fast. We didn't realize 'til now. She drew great pictures on those pages. They're great. But it's just something to show you what we do... We've got our own newsletter. [IK: Oh, that's great!] It's paid for by the [she names the family resource centre] because we don't have any money. We have a little bit now, but we're not going to use it for this kind of thing. One of our members edits it. I put in a few things each month. Mostly just the calendar [of events] and so on...when we send this out - we mail it out to about 100 people. Close to 100 providers, about 4 times a year. Now it gets some of them in to the centre, or into our program, or into our network if they call for something.

Some home child care agencies also offer newsletters (usually prepared by staff) and make other information and materials available to providers.

Several providers talked about the importance of broadening their training, to go beyond learning about child development. For example, one provider who had taken a number of courses through her local family resource program, commented on her interest in learning more about business management and leadership development:

[IK: Have you taken courses as you've gone along? I know you said you were going to workshops.] Yes, I've taken a lot of workshops and not all — they don't all pertain just to child care. The fact that you do home child care, I mean they mostly all pertain to child care because of where you're taking them – but I've taken some behavioural things and a lot of child safe things like that, and things about child development that I don't think teach you to solve all the problems, but they teach you to spot something. Last one I took was on speech development... [IK: Like identifying [problems]?] Identifying it. Telling the parent to please go and ask their doctor or whoever. Yeah, just to identify problems. I think that's the reason why we should take a lot of these courses. And then of course a lot of them are teaching us how to handle behavioural things, or there's craft ones, and there's stress management, and all kinds of things that actually do teach us something that we actually do use and every year, you can renew your CPR child care thing up there. And then of course being on the Board, I've been to a lot of other things that I think in turn help you when you are running your own business. We've been to leadership training and we've been to a lot of other things with the United Way, with conferences that they've had and you just – it all helps you even if ...it isn't saying you do this with the child. It doesn't necessarily have to pertain to the child. It just helps you cope with things.

Barriers to participating in formal and informal education and training programs

While many of the providers interviewed gave a number of indications about their serious interest in continuing their education, and in taking part in various learning opportunities, they also identified a number of barriers that made it difficult for them to take part in these activities.

Timing and logistics of training while working full time

Some of the providers interviewed talked about the difficulties they experienced with the logistics of attending workshops if they were held at night, after a full day of working with children. For example, one provider commented on how the agency she worked for offered learning opportunities both in her home and at other locations in the evening. In her view, the chance to learn in her own home during "paid working hours" was clearly preferable to having to take unpaid time away from her family in the evenings. Learning at home however, would cut down on her contact with other providers, and lessen the possibility of her getting support and reassurance from them. She also touches on another "sore point," the fact that providers are generally not paid while they are being trained, in comparison with agency staff whose pay usually continues while they attend inservice training, workshops and conferences:

...Well some of them [the workshops] can be done in the home...[IK: Oh, I see.] They come here when the kids are napping. [IK: ...and they do it with you?] They [her home visitor] do it with us, we'll watch a video and they'll ask questions...or they'll give you a video to watch and then they'll come and ask questions. [IK: Oh, I hadn't heard of that before...Do you like that better than going out, is it easier?] Well, preferably I like it better, because I don't really like the idea of having to do this stuff on my time. I think it should be done during working hours; like if it can be done during working hours then you do it during working hours while the kids are napping like now. I'd rather do it now than go at 7 o'clock at night and stay there 'til 9 when I've been working since 6:30, 7 o'clock in the morning. I don't want to go out the door again. I don't, and that's why I said, I don't like going to these things when they're at night; and they don't supply day care, so if I wanted to take my son, there would be nobody to watch him, so he'd be going...he's 14, so he's — you can't confine my son because he just likes to be outside. And, I'd rather do them in the house, I'd much rather do them in the home. Like, I know First Aid is hard, because First Aid you have to do in a big group, you can't do a First Aid course with one person. But I think this stuff here, when you have time, I think if your home visitor can get out, I'd rather do it at home, much rather do it at home than do it at night.

Other providers commented on the difficulties of taking part in day-time workshops that had to do with transporting young children in wintry weather for a short period of time, and the potential disruption to nap and lunch routines. The difficulties providers reported in attending agency workshops, however, pale in comparison to some of the difficulties experienced by providers who decide to study early childhood education while they continue to offer child care.

One provider described her experience of completing her field practicum and how it depended on her husband being able to take time from work to care for her own and the privately-placed day care children, and the loss of income while the agency-placed child was cared for by another provider:

I just finished. Actually I'm on my last course right now, I'll be finished in June. [IK: How do you manage that on top of everything else?] Well it's nights. I just, I don't know, it's just been part of my life I guess for the last three years, it just, I just do it. But, it's done. [IK: And you take, on average would you take one course at a time?] Two. [IK: Two. Wow, that's a lot of work.] Yeah it was, it was, it really, sometimes it was really heavy. [IK: What about field work, do they give you credit for...] I had to do three placements with them...and when I started doing their placements, I had to go...and that was fun, trying to find day care for the kids that I had here, as well as my own. [IK: And they wouldn't count what your doing?] Ah they did for one. I was supposed to do four, four week placements, and I got an exemption from one because of what I do, but I still had to do three. And it was interesting because my husband took holidays and stayed home with our two girls. And the agency said no, but the private children that I have, and actually the agency children – the agency parents wanted their children to continue here with my husband. And the agency said no because he hadn't been approved through them. And one parent was like – "Well, you know, I said she can so that should..." they put her in backup. [IK: There was no way they would come and (approve your husband?)...] They said they didn't have time, but the private children stayed here with him for the month that I was off... [IK: So did the children have to move to somebody else?] Ah one, just one, [IK: just one] just one. We only had the one agency child at that time. [IK: And did that child then come back?] Yes, yeah it was just for the month she went back when I came back...

This example is also interesting in that it demonstrates the fairly active role some providers' husbands take in caring for the day care children. In general, many agencies focus their efforts on providers and so do not tend to deal with men's involvement, often ignoring or overlooking it, unless there are parent complaints or other indications of problems.

Kinds and level of training offered

One of the major problems that some providers raised in relation to agency workshops had to do with the natural limitations associated with their short-term, periodic and relatively general nature. More experienced providers, in particular, seemed to crave an opportunity to learn about various aspects of their work in greater depth. For example, one provider had been talking about her sense that over the years she was caring for more and more children whose families were experiencing problems, she explained:

...and there's so many children out there now that are from unstable homes, they don't know how to relate with each other either. So nowadays, maybe that would be an idea with agencies. I don't know how they would implement it, but having providers who are more able to provide a

stimulating atmosphere for the children who need it the most, like these dysfunctional families...Actually, that's what I would like to see with the workshops...not psychology lessons, but something more along those lines. I have found that most of the workshops are just generalized. Diet workshops, or generalized toy workshops, or something. I'd like to get into something a little more in-depth.

This provider might have been a good candidate for a community college course. However, there was little sense that this was something she had considered, or something that her home visitor would have recommended.

An agency provider with seven years experience made similar comments about the superficiality of some workshops she'd attended, and suggested that having several consecutive workshops devoted to the same theme might be a way for providers to gain more in-depth knowledge about a particular topic:

..I think that would be the only thing I would like to see is a training program. I wouldn't even mind taking it, and I think there should be refresher courses. Not these little mickey mouse – don't repeat that – little mickey mouse, hour and a half things that everybody gets together... The only good one they had was on the sexual development of children and then it got into a lot of stuff and it was amazing, the feedback, you know. They actually had a second one to carry it on, and I was working that night I think, but that was a great one. It really got people out and it got them speaking out and talking. Even people that wouldn't normally talk got up and queried the instructor and it was great. Really, really good. [IK: It's an important area and one that maybe doesn't get discussed very much.] Uh hm...but see, that was more of an in-depth one. They should have more like that.

Still another very experienced provider expressed her frustration about what she felt was the repetitious and limited nature of the compulsory workshops her agency required her to attend. After a number of years the workshops had become boring:

And I will honestly tell you that a lot of older providers found it [the workshops] got to be very boring. That it was the same thing, and then they'd even get to the point where they'd say, but it's the same thing with a different name! You know, I'm getting tired of going. And there again, the agency had put a requirement on that you attend for a year. Well, for some of them it was getting pretty hard for them to attend for a year. I don't really want to go to that one again. I mean, how many times do I have to hear about child abuse? How many times to I have to hear about discipline? How many times do I have to hear about this subject, you know? And it was getting tough for some people and in some cases they were going to workshops that they really didn't want to go to, but they were attending because it was a requirement.

From her comments it seemed that there was little recognition on the part of the workshop organizers that more experienced providers might need and respond to different and more

challenging learning opportunities — or that they might be at a stage where they could do some teaching/sharing information themselves. A little later on in the interview this same provider explained:

...One year they asked me to speak at a provider dinner (she laughs), and in the middle of my speech I said, "Yes, and I'm tired of training home visitors." That kind of got a chuckle throughout the room, you know, but I was being, in a way I was being very honest. Like, I'm getting tired of home visitors that I'm training, and it's supposed to be the opposite. They're there for me, but in some cases, you've kind of wondered whether – who had the knowledge of doing day care in the home, you see. In many cases, home visitors with no...you know, I'm not putting them down or anything – but maybe [they] were just out of school, or had worked in a group centre or something and were changing to home day care. Many times I felt I actually knew more than that person that was supposed to be there supporting me. I had a better understanding of home day care.

Part of this problem may stem from the fact that many agencies approach their training from the perspective of trying to ensure a basic level of knowledge about various aspects of home carework, in order to "protect" the children who they place there. Providers' needs, as workers in their own right, are not always taken into account, except where they may touch on children's well-being and safety. In general, there does not appear to be enough consideration of providers as individuals who bring different experiences and learning needs to their work, nor as workers who have interests, ambitions and goals for personal development.

To be fair, in most parts of the country, agencies or other provider support programs have had little funding or other encouragement to develop more than the most minimal orientation and training programs for providers. For example, in Ontario, for many years agency funding for provider training and support was always listed as an administrative, rather than a program cost in budget submissions. This had the effect of making the costs of administration seem high, so that any efforts to further develop training and support were seen as a "frill" or "Cadillac" care, and the agency staff who tried to develop them judged as being frivolous and unrealistic. As providers' comments indicate, however, in the long run, the lack of response to their learning interests and personal development can result in boredom and a sense of being dead-ended, leading to feelings of discouragement, which in turn, may contribute to the high rates of provider turnover reported in some studies.[20] For agencies, this leads to the additional costs of recruiting and training new caregivers. It would be interesting to see if this same funding were invested in developing providers as workers and finding ways to advance more experienced providers, whether the turnover rates would go down.

Negative reactions to "professionalism"

One of the tensions several providers articulated in relation to taking part in various training or more formal education programs had to do with their feelings that "professionals" did not respect their ideas and the sense that the expertise and experience they brought to their learning was

often dismissed. The dilemma is not the one suggested earlier by Kontos, Machida, Griffin & Read of choosing "mothering" over "training," but rather seems to be a reaction to the condescension and arrogance they associated with some professionals, and with some "professional" training.

One provider who had completed some courses in ECE expressed it this way:

...I know somebody who has their ECE and they keep stressing the fact that they have their ECE. And I wouldn't leave my own kids with this person, because this person has informed me that when you do your ECE, as long as you're thinking on the same wave length as the instructor, and as long as you write down what you think that person would agree to, you'll pass. Even if it's something that you wouldn't do yourself; like...if you wouldn't set up a routine, but you know the ECE person thinks you should set up a structured routine, as long as you write down that you would set it up, even if you wouldn't, then you'll pass. And that really disturbs me, okay. The way that this person in particular deals with her children, I find totally unacceptable, and the fact that she can go around saying that she has her ECE and is better than me, really, really bothers me. And I sit there and say, if you can have your ECE and you can get a job in a day care centre, and I don't have my ECE, and personally I feel I am the better day care provider, I don't want my ECE...if that's what comes out of it... Personally, I think I have educated myself a great deal, and possibly even more than this individual person. Mind you, her courses were one thing, but outside of her courses for her ECE, was she interested in learning anything more than what she actually had to? Because, I was...

In this providers' view, getting an ECE was associated with being dishonest and compromising some of her beliefs about how children should be cared for, rather than seeing it as an experience that could expand and build on her existing knowledge. Interestingly, when I questioned her further, she commented on some of the characteristics that might make further training more attractive:

[IK: But if you could find the right sort of course would you be interested in doing that someday, do you think?] Getting my ECE? [IK: uhum.] If I thought that I could do it fast enough and still do day care? Yes. But, I think doing it part-time is a very long process, and I don't think that I would want to go that long. And to have the attitude now, because this person has said that as long as you think on the same wave length as the instructor you're going to pass, then I sit back and think, well I don't think I want to do that that way, like... [IK: I'm not sure that would be true of all courses...] I don't know... [IK: Do you know where she took her training?] No. [IK: Because you liked the (I name the place where she studied) one, didn't you?] Oh yes...I thought that one was really good, I really enjoyed it. I enjoyed the people who were also taking it with me and some of them had been day care providers for quite some time, they were just going back as a refresher course which is something that I thought was pretty interesting, because I would have liked to have done it as well.

In the above example, the provider refers back to the logistical problem discussed earlier of having to "still do day care" and earn an income while studying. It is not just impatience with the time it takes to learn that she is expressing; in her case, her husband had recently been laid off his job and so she was the sole source of income for her family, and could not afford to work less or otherwise jeopardize her income while studying. It should be recognized that there are few financial incentives to studying ECE, unless a provider is interested in taking up a career outside her home. Home child care providers who are graduates of formal training programs do not necessarily earn more, have more benefits, or receive greater public recognition; most of the benefits they gain are the altruistic ones associated with the greater self-confidence and skills acquired through the disciplined acquisition of knowledge and supervised practice.

Another provider, originally trained as a nurse's aide, raised a concern about how she saw "professionals" working with people, and the fact that a professional is supposed to be "calm, cool, and collected." Although she was referring to nursing, her comments also have bearing on home child care, and her feelings echo those expressed by some providers that centre-based care is too impersonal and institutional, and that the more "formalized" relationships that characterize those settings, are not fully transferable to home child care:

[IK: You said you were trained to do nursing originally. Have you ever thought about going back to doing that?] No, I was thinking about going back to school, for psychology for children. I'd love it. Children seem to be able to talk to me about anything. Everything and anything. And I just have the patience. One thing is, I don't know, like even in nursing sometimes, your heart kind of...they say you're supposed to be calm, cool, and collected, you know, and you're not supposed to get attached. And you know, I worked with older people too and I mean they die, and this old lady leaves me a brooch. And it's like, I'm sorry, I've got feelings, whether you want to title me a nurse or not, I don't care. She's a blind lady and I used to write her letters for her and she's given me a personal part of her life, like getting her to write letters and they'd wait for me literally to come in, you know, to do certain things. And the other nurses, you know the ones that were actually the RNs or RNAs, wouldn't give the backrubs or the care that they're supposed to get and here I am doing it all. I just had a knack for [it] – I've been a people person, that's what a lot of people say...

While many providers interviewed in this study have given clear indications of their continuing interest in learning and upgrading their knowledge and skills as home child careworkers, at the same time they have some discomfort with the notions of professionalism they are asked to adopt, and have questions about the appropriateness of certain values and practices for home-based care. The marginalization and devaluation of home-based carework by child care professionals only adds further insult to injury. For example, Dunster was quoted in a recent article on child care in the *Toronto Star*:

Many of the [Child Care Providers Association] members say they have been hurt by comments from proponents of licensed day care that unlicensed care is inferior and possible harmful. They

have to constantly justify themselves when they hear comments such as, "God help your children" (in unlicensed care). It's really tough for a caregiver to hear what she does talked about in that way.[21]

What is needed to underlie the training and educational opportunities offered to home child care providers is a serious rethinking of our basic assumptions about what it means to be a professional careworker in a home setting. Related to this is the need to develop an alternative construction of professionalism that recognizes and builds on the unique nature of carework in a home and family based setting, and on the sense of interest, responsibility and ethics of caring that many providers bring to their work.

Implications for Developing Education and Training Programs

The following is a brief summary of some suggestions for future development of education and training programs discussed at various points in the paper:

- Recognize and affirm the knowledge and skills providers bring to their carework gained from prior training and practical experiences in offering home child care, or from their work in other human services. Recognizing these skills and prior experience also means that it is necessary to provide for more individualized, progressive learning opportunities that allow providers to gain more in-depth learning around special topics, rather than simply repeating basic and introductory orientation courses.
- Think through how a career ladder and other developmental opportunities can be provided to enable more experienced providers to develop professionally. The success of provider networks and associations has demonstrated that experienced providers have a lot to offer in helping to orient, train and mentor less experienced providers. In addition to learning more about various aspects of their carework, these contacts also work to connect providers with one another in ways that cut down on their isolation and increase the exchange of social/mutual support.
- Make education and training more accessible. At present, there is generally limited funding available, not only to support the development of various training and educational opportunities at all levels – by agencies, provider networks, family resource centres, and colleges and universities – but also the lack of funding to enable providers to attend them. There is also a need to develop more opportunities for providers to learn at home while they are working, through the provision of extension courses and other outreach approaches.
- Community colleges and universities need to recognize the unique nature of home child carework and design courses that address the specific needs of careworkers in home settings. Practicum requirements, course material, and assignments should be designed to build on, and further an understanding of the special characteristics of home carework, rather than

simply adapting materials designed for workers in centre-based programs. For example, home child practicum assignments might involve the provider contacting and getting together with other neighbourhood providers to organize a playgroup; developing and delivering a workshop for other providers in a local family resource centre; keeping logs and doing observations on their home day care and own children; developing a plan for communicating with children's parents, and so forth.

- Rethink notions of "professionalism" as they apply to home child careworkers, and don't simply adapt from other groups notions of professionalism that alienate and devalue the values and beliefs of providers.
- Develop opportunities for caregivers whose first language is not English to take ESL training courses. Many providers who are recent immigrants are unable to fully benefit from existing training opportunities because their spoken English is limited, and the challenges of written work related to formal training seem too formidable. Despite their language limitations, many of the providers in this study expresssed interest in further learning and would likely respond if appropriate training were offered. Courses and in-service training that promote multi-cultural sensitivity, awareness and cooperation among all providers are also essential.

Endnotes

1. Powell and Bollin (1992), p. 173
2. Ibid, p. 174
3. Kyle, 1996; Pence & Goelman, 1987
4. Bronfenbrenner, 1979; Garbarino, 1990
5. Owen, 1989, p. 23
6. In Ontario, home child care providers are not licensed directly, but may choose to become affiliated with a licensed agency that assesses their compliance with minimum provincial standards, monitors their homes, and offers training and support. The majority of providers work independently, and are not required to meet any standards beyond that of caring for fewer than six children.
7. Reinharz, 1992, p. 25
8. Ibid, p. 18
9. Bogdan & Biklen, 1992, p. 49
10. DeVault, 1990, 1991
11. Ibid, p. 29
12. Richards and Richards, 1994
13. Tuominen, 1995, p 13
14. Norpark, 1989, p. 117
15. Ibid, p. 60
16. See Denzin, 1994
17. Johnson & Dineen, 1981, p. 61
18. See for example, Kontos, Machida, Griffin & Read, 1992
19. Ibid, p. 204
20. See for instance, Norpark, 1989, and Read & LaGrange, 1990
21. *Toronto Star*, Jan. 25, 1996, p. B5

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